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Official Journal of The Catholic Hospital Association of the United States and Canada

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ADMINISTRATIVE FORUM

Conducted by Victor E. Costanzo, M. H. A.

Constitution and by-laws

With this issue we enter upon the New Year. Therefore by way of preface we would like to extend greetings to all of you. May the New Year be for you one of reward in the service of our Lord.

* * * *

It seems worthwhile to direct your attention towards the constitution and by-laws of your hospital. From the viewpoint of first things first, let us consider this basic factor in the administration of the voluntary non-profit hospital.

In studying the question we will learn from *Hospital Organization and Management*, written by Dr. Malcolm T. MacEachern, and the *Manual of Hospital Standardization* compiled by the American College of Surgeons that there are the factors of ownership of property and the making of provisions for the operation of the hospital.

Provisions for the ownership of property must conform with the laws of the state. Therefore it is profitable to quote the Manual which stresses that you engage a lawyer since "the procedures and documents to be used depend upon the laws under which the corporation is to be organized." We all see the value of this advice.

Perhaps we are more interested in the provisions for the operation of the hospital. Our interest was originally attracted by the numerous questions which were received concerning the medical staff by-laws. By-laws of what, and the answer may be found in the constitution of the hospital.

Then there is the further emphasis contained in ownership and borne out in the operation of the hospital that the hospital must have well-defined control. Always the hospital is to all intents and purposes legally represented by its Board of Governors, Trustees, or Directors as the case may be.

They may not delegate that authority. The model constitution

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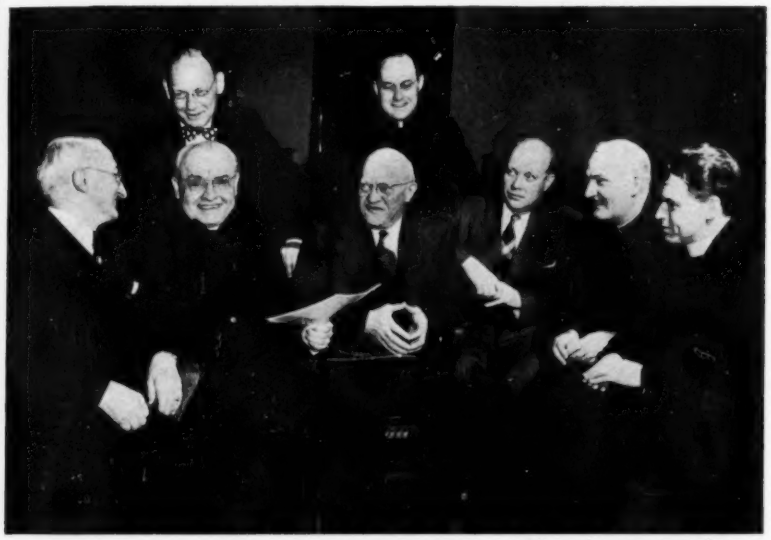
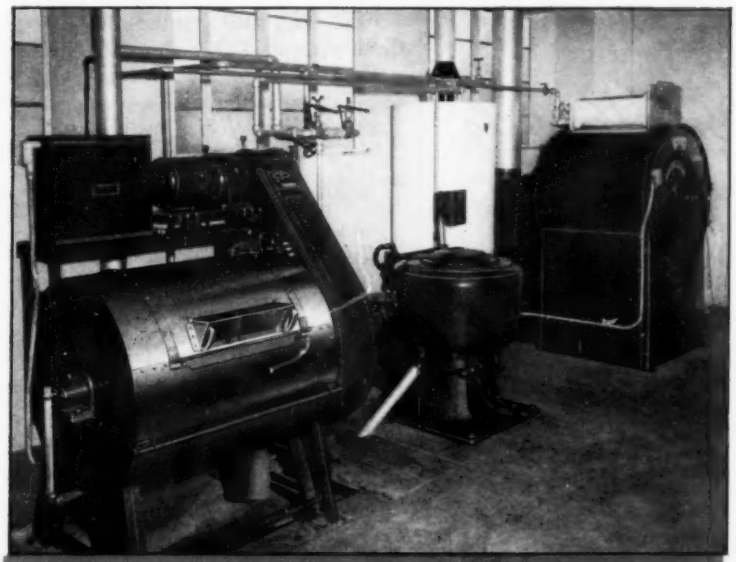


The second Annual Alphonse M. Schwitalla Lecture was delivered in St. Louis by Dr. Arthur C. Bachmeyer on November 29. Picture shows, L. to R.: Harry J. Mohler, Administrator, Missouri Pacific Hospital; Father Schwitalla; Dr. Bachmeyer; Dr. Melvin A. Casberg, Dean, St. Louis University School of Medicine; the Rev. John J. Flanagan, S.J., Executive Director, Catholic Hospital Association; and the Rev. Edward T. Foote, S.J., Regent, St. Louis University School of Medicine. Standing are M. R. Kneifl, and the Rev. Joseph B. Winter, Director of Hospitals of the Archdiocese of St. Louis. The lecture is sponsored annually by the graduate course in hospital administration of St. Louis University in co-operation with C.H.A.

Congratulations! *to Santa Teresita Sanatorium, Duarte, Calif.*

on its Efficient, Modern, Laundry Department



Requiring minimum space, the efficient 3-Machine Laundry at Santa Teresita Sanatorium consists of CASCADE Washer, Solid Curb Extractor and gas-heated AIRCRAFT Drying Tumbler.

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SOLUTION: Sisters called in our Laundry Advisor. Carefully analyzing volume of linens required, he submitted plans for a compact, simple-to-operate unit to provide all benefits of modern, high-speed equipment. Plans were approved, and the new laundry installed.

RESULTS: *Only one person* is needed to operate the modern equipment which assures an abundance of clean linens for all departments throughout the Sanatorium. Laundering quality meets strictest sanitation standards. Most welcome savings are made in laundry costs.

●

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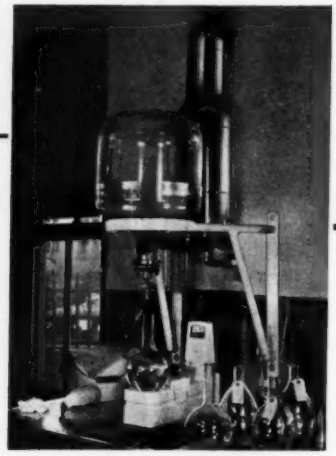
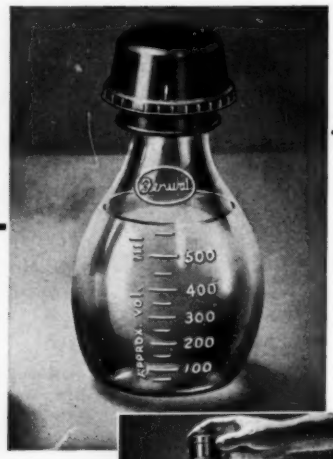
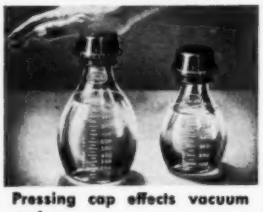
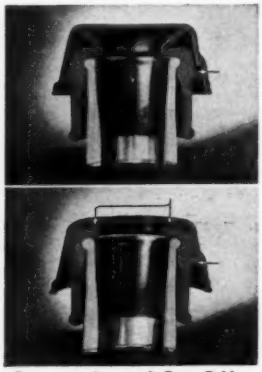




Collar is placed over flask, hugging neck and lip of container; cap is placed loosely over cover during sterilization.



Pressing cap effects vacuum seal.



Cross sections of *Pour-O-Vac* before and after pressing cap showing how vacuum-tight closure is effected.

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BACTERIOLOGICAL APPARATUS

(Continued from page 4A)

and by-laws for a hospital corporation published in the 1947 issue of the American Hospital Association Directory states in relation to the medical staff "acting on the advice of the medical staff, or when no such staff exists, with the best medical advice obtainable the governing board shall *appoint* a medical staff composed of regular physicians and shall see that they are organized in such a manner as to secure the best possible results. In the professional care of patients the attending physician appointed to the medical staff shall have full authority subject only to the policies stated by the governing board. In administrative matters the medical staff, as an organized body, shall act in an advisory capacity, this function being carried on through the Joint Advisory Committee."

There is no attempt at originality in this presentation. We suggest these are some of the references you should study for your knowledge and information.

Latest Figures on P.L. 725 Indicate 954 Projects Approved

Figures released recently by the Federal Security Administration reveal that as of October 1, 1949, 954 hospital projects had been approved, approximately 400 were under construction, and 50 had been completed and were operating. The majority of these are small general hospitals of 50 beds or less capacity located in small towns or rural areas. Approximately 37,000 beds will be provided for by this construction, for four per cent of the total need, which has been estimated by F.S.A. at 900,000 additional beds.

As a result of the new amendments to the Hospital Survey and Construction Act, which among others raised the amount of Federal grants available annually from $75,000,000 to $150,000,000, prospects for new hospitals and important research in the field have been materially enhanced. One part of the research program will investigate the manner in which better linkage can be provided between large urban hospital centers and others.

Looking for Shortcuts?

There's a more practical one you can start using tomorrow—with better results. It is VENOPAK, Abbott's completely disposable venoclysis unit, with Abbott's ampoule-quality solutions. Sterile, pyrogen-free, ready for instant use, VENOPAK obviates the entire time-consuming cycle of assembling, disassembling, washing and sterilizing of ordinary equipment. It also eliminates any possibility of cross reactions. You use VENOPAK once *and throw away.* See a *few* of the advantages of VENOPAK below, then ask your Abbott representative to prove *all* the advantages of VENOPAK with Abbott Intravenous Solutions—or write to HOSPITAL DIVISION, ABBOTT LABORATORIES, North Chicago, Illinois.

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This month with the ASSOCIATION

Convention Plans Develop

In preparation for the Association's 35th Annual Convention scheduled for Milwaukee, June 12–15, 1950, arrangements for the technical exhibit, all-important feature of the Convention, were reviewed with the Hospital Industries Association on Saturday, December 10 in Chicago. Mr. Tom Murdough, President, presided at the meeting. M. R. Kneifl and A. C. Janka, Director of Exhibits, represented the Association in this meeting.

Improving Patient Care

On Saturday, December 17, a special subcommittee of the Joint Committee for Improving Care of Patients met to consider problems relating to licensing of the practical nurse and other hospital staff members. Representing the Association was the Reverend John J. Flanagan, S.J., Executive Director.

Conference Officers Meet in Annual Session

The second annual meeting of the Officers of the Association's Conferences took place at the Stevens Hotel, Chicago, on Wednesday and Thursday, January 4 and 5.

The meeting opened at 10:00 o'clock Wednesday morning under the direction of the President of the Association, Monsignor John W. Barrett of Chicago. The program focused on "Licensing of Hospital Staff Members," "Blue Cross–Blue Shield Developments," "The Hospital Survey and Construction Act — the New Amendments and Changes in Regulations," the program for the Association's 35th Annual Convention in Milwaukee, the pattern of conference activity within the Association, recommendations for changes in By-Laws of the Association, etc.

Assisting in the meeting were Father Flanagan, Msgr. Goebel, Msgr. Towell, R. J. Pendall, and M. R. Kneifl.

The Annual Meeting of the Executive Board

The annual meeting of the Executive Board of the Association took place at St. Bernard's Hospital, Chicago, on Friday and Saturday, January 6 and 7. Attending the meeting were: Msgr. John W. Barrett, Chicago, President; Msgr. George Lewis Smith, Aiken, S. C., Past President; Msgr. John R. Mulroy, Denver, Colo., President-Elect; Msgr. H. Joseph Jacobi, New Orleans, La., First Vice-President; Msgr. M. F. Griffin, Cleveland, Ohio, Second Vice-President; Sister Helen Jarrell, R.H., Chicago, Secretary; Sister Mary Seraphia, S.S.M., St. Louis, Mo., Treasurer; Sister Mary Claire, S.S.A., Victoria, B.C.; Sister Mary Louise, S.S.J., Toronto, Ontario; Sister Lydia, D.C., Indianapolis, Ind.; Sister Mary Fidelis, Houston, Texas; Sister Martha Mary, O.S.F., Brighton, Mass.; Sister Mary Rita, Nampa, Idaho. In addition, Father Flanagan and M. R. Kneifl attended.

The principal items of business concerned the finances of the Association for the year 1949 including the budget report for 1949 and the budget for 1950, the program of activities for 1950, the 35th Convention, relations with other associations, the national health program, HOSPITAL PROGRESS, the progress of the reorganization program, etc. In an early issue of HOSPITAL PROGRESS, a more complete report of this meeting will be published.

Dayton Nurses Meet

On Sunday, January 8, Father John J. Flanagan, S.J., Executive Director of the Association, addressed the Dayton, Ohio, Council of Catholic Nurses discussing "Trends in the Nursing Profession."

The Annual Directory of the Association

As this is written, the Central Office staff is devoting most of its

(Continued on page 10A)

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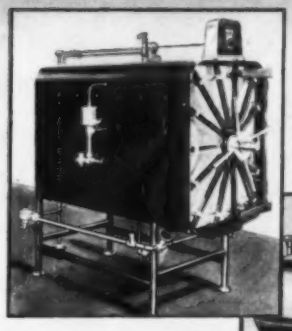

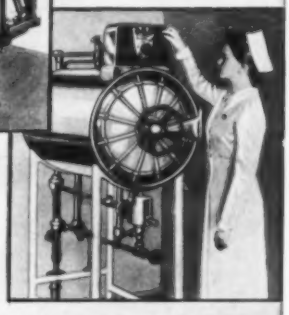

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(Continued from page 8A)

time to the assembly and tabulation of data for the 21st annual edition of the Association's directory. This annual reference number of HOSPITAL PROGRESS includes directories of schools of nursing — collegiate, hospital three-year and practical nurse programs, a list of religious groups conducting hospitals and schools of nursing, and health care facts in addition to a complete directory of hospitals and health agencies under Catholic auspices in the United States and Canada.

Two Bishops' Representatives Made Domestic Prelates

The Right Reverend Monsignor Ralph J. Glover, Ph.D., Archdiocese of Newark, New Jersey; Director of the Associated Catholic Charities; founder and Director of the Catholic Hospital Council of New Jersey; a member of the Catholic Hospital Conference of Bishops' Representatives for the Archdiocese of Newark.

The Right Reverend Monsignor John J. Shanley, Ph.D., Diocese of Paterson, New Jersey; Director of Associated Catholic Charities and of Catholic Hospitals; Director of Diocesan Council of Catholic Nurses; educator, and social scientist, a member of the Catholic Hospital Conference of Bishops' Representatives.

The Officers of the Association and the Editors of HOSPITAL PROGRESS join in extending congratulations to the Right Reverend Domestic Prelates for this recognition of their accomplishments.

Monsignor Griffin Goes to Rome for the Holy Year

Sailing from New York on Monday, January 9, were Monsignor Maurice F. Griffin of Cleveland and his sister Miss Helen Griffin to attend the Holy Year ceremonies in Rome. While abroad, Msgr. Griffin will visit France and England in addition to Italy.

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The Calendar

January, 1950

Officers of Association's Conferences
Jan. 4–5, Second Annual Meeting, The Stevens Hotel, Chicago, Illinois
Catholic Hospital Association
Jan. 6–7, Executive Board — Annual Meeting, St. Bernard's Hospital, Chicago, Illinois
Council on Prepayment Plans and Reimbursement
Jan. 30–31, American Hospital Association, Statler Hotel, Washington, D. C.

February

Annual Congress on Medical Education and Licensure
Feb. 6–7, American Medical Association, Palmer House, Chicago, Illinois
Mid-Year Conference of State Presidents and Secretaries
Feb. 10–11, American Hospital Association, Drake Hotel, Chicago, Illinois
Wisconsin Conference of Catholic Hospitals — Annual Meeting
Feb. 14–15, Workshop Conference on Cost Analysis Procedures and budgeting for Schools of Nursing, Milwaukee, Wisconsin.

March

American Protestant Hospital Association
Mar. 1–3, Annual Meeting, Chicago, Illinois

(Continued on page 12A)

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Crysticillin Suspension

SQUIBB Procaine Penicillin G in Aqueous Suspension

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no refrigeration required.

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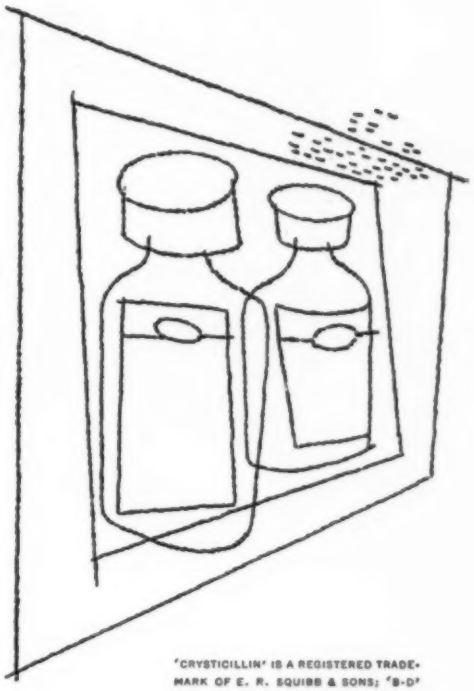

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SQUIBB A LEADER IN PENICILLIN RESEARCH AND MANUFACTURE

Commission for the Improvement of the Care of Patients
Mar. 9–10, Drake Hotel, Chicago.

Catholic Press Association
May 24–26, 40th Annual Convention, Rochester, New York

April

47th Annual Convention, National Catholic Educational Association
Apr. 11–14, New Orleans, La.

Iowa Conference of Catholic Hospitals
Apr. 20, Kirkwood Hotel, Des Moines, Iowa

May

National Council of Catholic Nurses
May 4–7, Los Angeles, California

American Council on Education
May 5–6, 33rd Annual Meeting, Palmer House, Chicago, Illinois

June

Catholic Hospital Association
June 8–15, Milwaukee, Wisconsin
June 8–12 — Second Institute for Hospital Pharmacists
June 10–11 — Conference of Catholic Schools of Nursing
June 12–15 — 35th Annual Convention, Municipal Auditorium

Summer School — Hospital Administration
June 20 — July 22, St. Louis University
June 20–July 8 — Principles of Hospital Administration

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"Joe Martin had called on me several times asking for some of our business. Today I called on him to see what sort of an outfit he had. I was impressed. His office had an air of quiet efficiency. It was pleasant to look at too. This man knows how to work . . . how to get things done," I thought.

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Father McGowan, Dr. Anthony J. J. Rourke, Appointed to Federal Hospital Council

Among three new members of the Federal Hospital Council are Rev. Donald A. McGowan, Director of the Bureau of Health and Hospitals, N.C.W.C., and Anthony J. J. Rourke, M.D., Superintendent of the Stanford University Hospital, San Francisco, Calif. The third new member is Jonathan Daniels, editor of **The News and Observer,** Raleigh, N. C.

As a result of recent amendments to Public Law 725, the Council, which was organized under the Hospital Survey and Construction Act of 1946, will have new responsibilities, including programs of research and demonstrations related to hospital services and to the co-ordination of hospitals.

It's a Thought

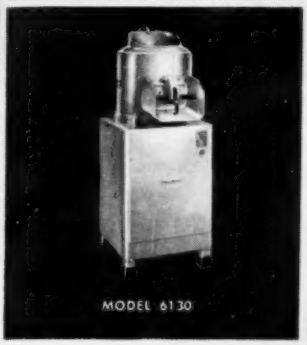
Hospital Pays Cash to Patient-Critics

Hospitals across the country are using patient surveys to improve both their service and their public relations. One hospital in Newfoundland is going one step farther to elicit patient comment, which often proves valuable in improving hospital routine. Each month, this hospital awards five prizes of five dollars each to patients submitting the most valuable suggestions relative to any phase of hospital management. The suggestions must be submitted in writing, and may be critical or laudatory in nature, but they must be constructive. Needless to say, the cash awards are stimulating a good deal of constructive thinking among recuperating patients.

Plans Progressing for 4th International Nurses' Congress

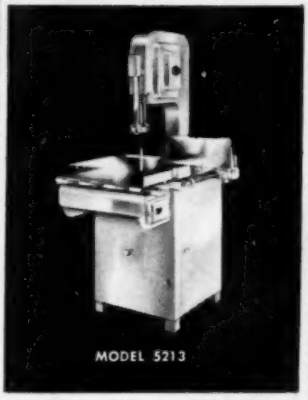
The Fourth International Congress of Catholic Nurses, to be held Sept. 5–9, 1950, in Rome, promises to be as great a success as the last one held in the Holy City in 1935, according to information received from the Rev. Edward Garesché, S.J., International Spiritual Director of the International Committee of Catholic Nurses' Associations.

PEELERS



FOOD CUTTERS

MEAT SAWS



MEAT CHOPPERS

TENDERIZERS

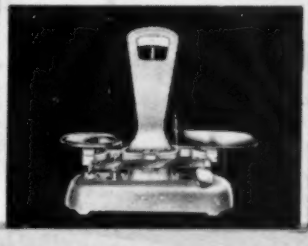
SITUATIONS WANTED

COFFEE MILLS

FOOD SLICERS

MIXERS

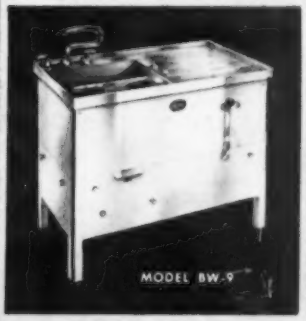
SCALES



DISHWASHERS

SITUATIONS WANTED

GLASSWASHERS



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SITUATIONS WANTED

New Books

Ward Management and Teaching

Jean Barrett, R.N., M.A., Appleton-Century-Crofts, New York. 1949. 399 pages. Illustrated. Price, $4.00.

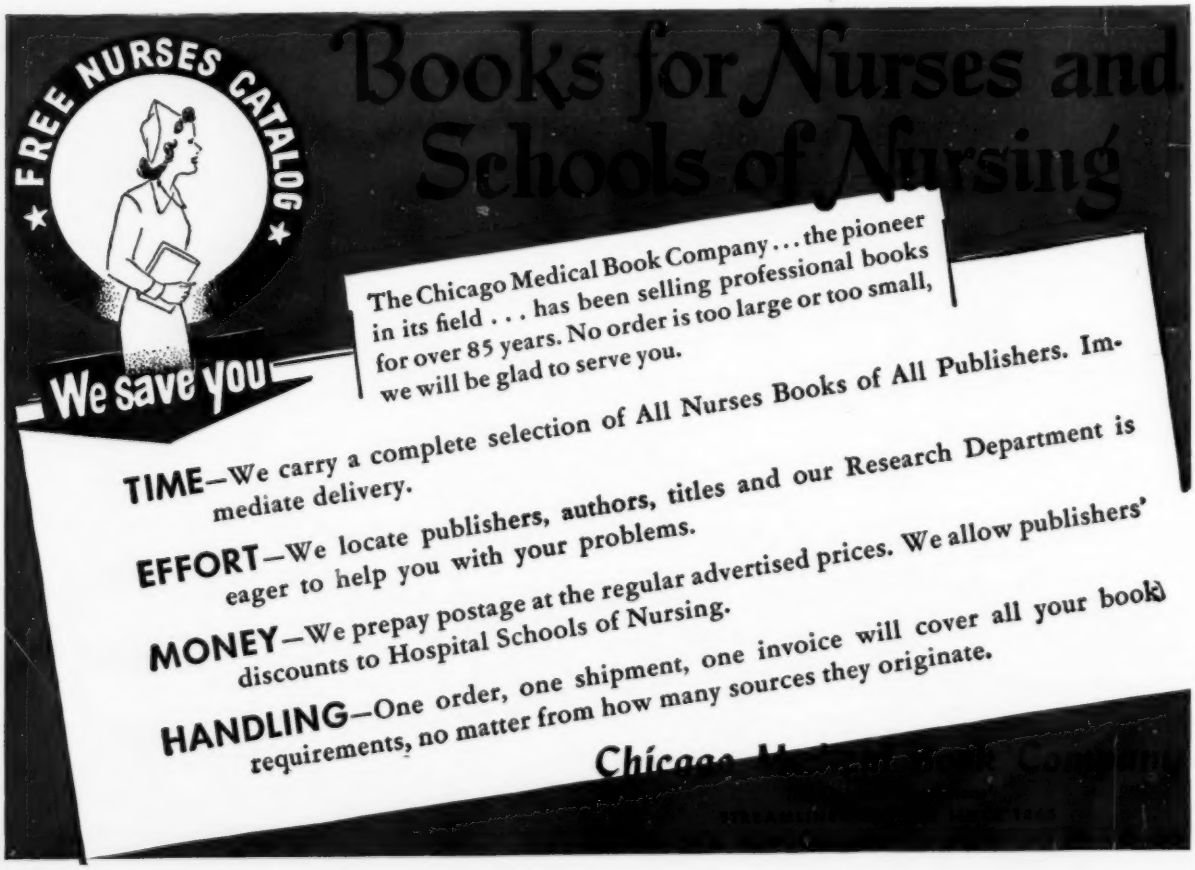
This book, written primarily for young graduates who are preparing themselves for positions as hospital head nurses, is not only a valuable contribution to nursing literature in general, but an excellent reference for all members of the hospital's administrative and educational staff. It has been written by a teacher who is competent not only in the art and science of good nursing care, but through years of experience in ward management and teaching has come in contact with every type of nurse within the scope of hospital and school of nursing administration. The author's familiarity with the daily problems encountered by head nurses is apparent throughout the book and she offers many practical approaches to the solution of these problems.

The subject matter has been organized conveniently into sections dealing with the various functions of the head nurse. The book is divided into five parts, namely, Part One deals with the place of the head nurse in the hospital and nursing school; Part Two with the responsibility of the head nurse for the quality of patient care; Part Three with her responsibility for good ward management; Part Four with the educational responsibilities of the head nurse in which the author stresses the general principles of ward teaching, and good ward teaching methods; and Part Five deals with the head nurse's responsibility to herself and to her profession. In the last chapter, Miss Barrett ties together the many elements of the head nurse's responsibility and thus gives an over-all picture of her position.

Throughout the book there are many excellent features which increase the text's usefulness. The author has presented many forms, records, and other devices used by the head nurse in management and teaching. Annotated bibliographies at the end of each chapter as well as numerous suggestions for continued study and application by the student are added value to the book. A thorough reading of the book impresses one that the author has a deep consciousness of the needs of the sick and although she places a great deal of emphasis on the education of the nurse for her position, it is evident throughout the book that at all times this education is directed toward the better care of the patient.

The text emphasizes the importance of holding the standards for the position on a level commensurate with the demands which must be made by the competent head nurse. This book has the merit of being easy to read, and should be recommended to all head nurses and all young graduates preparing for positions as head nurses, and should also be an excellent guide to all instructors of head nurses and clinical instructors. The value of the book is based on many years of personal study and experience.

Reviewed by: *Sister M. Digna, R.N., M.A., Director, St. Agnes School of Nursing, Fond du Lac, Wisconsin.*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HOSPITAL PROGRESS

JANUARY, 1950

Does new epoch call for new planning?

AN EDITORIAL

THE mid-century month of January 1950 opens the door to an era which will call for great spiritual and social adjustment. The preceding half century has been of phenomenal material and technical development. We are very conscious of this development. Some are inordinately and blindly proud of it. Many are confused because this development has thrown them out of step with spiritual and social values which were needed as stabilizing influences. Others are frankly concerned that spiritual values and basic Christian principles of living are being lost and that man is being subjected to the unnatural and unbalanced diet of meat alone.

Undoubtedly we have closed a period in history which may well be known for its devotion and subjection to organized planning and activity. Today our institutions cannot be respectable unless they are standardized; education is deficient if it is not accredited; hospitals are not considered good unless they are approved and no administrator in the health field dare face his associates if he has not attended three or four conventions or institutes each year. In most instances the badge of excellence or approval depends on physical and material criteria. In all fairness we should not deny to this movement the credit which is due to it — the improvement of the physical and material side of health care. We trust, however, that this worthwhile growth and development may not crystalize at the level of formalism and a blind worship of standardized procedures for their own sake.

In the field of health we should not forget that the ultimate objective of standardized procedures and approved institutions is the cure of suffering human beings — human beings in their total needs, physical, mental and spiritual. Approvals and standardized procedures can be empty claims to honor if they do not minister to the total human needs of people who are sick.

We begin the second half of this century with the blessings of a Holy Year. It is a year which offers spiritual riches and supernatural opportunities. We hope that it will set the tone for a renewed interest in the spiritual and social needs of man so that this phase of living may catch up and be integrated with the material progress of the last half century.

This issue of HOSPITAL PROGRESS is devoted to hospital construction with considerable emphasis on planning. Administrators in charge of Catholic hospitals will be interested in this special feature. It would be regrettable, however, if they did not give as much attention in their planning to religious and charitable needs of the American people. There are many who will offer material advantages and help, but too few who will minister to the soul.

We hope, of course, that the new year 1950 under the inspiration of the Holy Year celebrations will bring special graces to our hospital personnel and special blessings to our hospitals. We express the wish likewise that it may set a pattern for the second half of the century by ministering more intensively and effectively to the spiritual and Christian social needs of men. Most of all we pray that the Charity of Christ may not be impeded or supplanted by too much dependence on material progress and technical self-sufficiency.

Are we building too much?

Evaluate local conditions:

The Most Rev. Karl J. Alter, D.D.

His Excellency, the Bishop of Toledo, draws on his wide experience for this article. He is Episcopal Chairman of the Catholic Hospital Association.

The question presented in the above title cannot be answered with a simple yes or no, but needs careful distinction before an adequate reply can be given. What is meant by "Overbuilding?" Can it mean that the present unprecedented demand for general hospital service may diminish markedly? Can it mean that the public, educated to the right understanding of hospital service, may some time in the future lessen its interest in voluntary hospitals in contrast to government operated hospitals? Can it imply that the phenomenal growth of prepayment plans of all kinds for hospital and medical care will be stabilized or discontinued? Can it mean that the voluntary hospital system must examine its conscience before undertaking further development and expansion? Can it imply that for each hospital project of whatever kind there must be full investigation of all pertinent facts to justify its development and its real mission?

While all of these questions deserve consideration, it must be pointed out that the answers will center around the particular conditions prevailing in the local community and the region which it serves. For that reason, we have chosen to answer this last question first, hoping thereby to point out some of the areas to be studied before going forward with a hospital proposal. Only on the local level, and only with the individual hospital project, no matter what it is, can the question "Are We Overbuilding?" be answered.

That there is a general need for additional hospital beds has been established beyond any doubt. Some communities have adequate hospital facilities, some have not. Some localities lack facilities for special services, although their general hospital services are adequate for the needs of their population. Not only the need for beds but the type of service required enters into the problem posed by this question. Although the United States leads all other nations in the number of hospital beds, nevertheless, these facilities are not evenly distributed — with the result that there are areas now oversupplied and others with insufficient or no hospital services.

To be sure, state surveys have been made from which have emerged two important elements: one — an inventory of existing and acceptable hospital facilities, and two — a plan for the development of hospital services in each state. Each such hospital plan is related to the conditions of the state, such as its population distribution, urban and rural, the dominant and other economic activity, trade centers, communication systems, the availability of professional personnel, climatic conditions, etc. This has been brought about through The Hospital Survey and Construction Act (Public Law 725 — now known as Public Law 380). While other phases of health care come within the scope of this law, we are considering only hospitals and hospital services.

Criteria for Evaluation:

In establishing need for additional hospital beds or services in the local community, it is necessary to develop and apply certain criteria by which to make an evaluation of the requirements of the locality and the region which it serves. It is not only necessary to study these needs — that is

(Continued on page 4)

Too little planning:

J. R. McGibony, M.D.

Dr. McGibony, Chief of the Division of Medical and Hospital Resources, U.S.P.H.S., is also Consultant to the National Security Resources Board.

Too often, in sports, we tend to watch the scoreboard and forget the rules of sportsmanship which should govern the game. Too often, in the hospital field, we tend to concentrate on figures, on dollars and numbers of beds, and forget the ultimate goal of any good local or national hospital program — better patient care. To reduce patient needs to a mathematical formula is a stage which will not be reached until much more tangible criteria are developed. It is far easier to determine the demand for hospital services than it is to undertake the difficult task of really measuring the need for such services.

DOES "4.5 PER 1000" HAVE REAL SIGNIFICANCE?

It was a simple matter to state a limit, in number of beds, beyond which Federal aid would not be forthcoming to assist in construction of hospitals. That figure, 4.5 general beds per thousand population, may or may not bear any relation to the actual needs of a community or a region. It was arrived at by ascertaining that in some areas, where certain limiting factors had been partially removed, the demand for hospital services required about that number of beds.

Not so simple were the factors involved. There were financial considerations, particularly where Blue Cross, commercial, or industrial insurance plans were in rather general use by the population. Other factors

(Continued on page 5)

Three hospital authorities answer a question which vexed many administrators during 1949, the year of the first post-war economic "dip."

So many factors:

Sister Isabella

Sister Isabella is the Provincial Treasurer and Supervising Accountant of the Daughters of Charity of St. Vincent de Paul, St. Louis Province.

CAUSE AND EFFECT

Many of our readers learned long ago that every effect has its cause. The caption of this article has several well-defined causes that easily suggest the expression of an opinion based on actual yearly surveys of over 20 general hospitals.

There seems to be an epidemic of hospital construction in the form of rehabilitation, wings, and entirely new structures. It cannot be the policy of "keeping up with the Joneses" — it must be the lure of Uncle Sam's generosity in giving a large share of the cost of the expansion after the hospital has guaranteed the balance.

Where is the cost of the balance to come from? One of these may be the result of a drive for the building fund, and the final dollars of the balance may be gathered from donations, mortgage, or the doubtful source of surplus. Control of accounts receivable is another important factor in arriving at a surplus, while a cost analysis of the various departments of a hospital puts one's finger on the financial pulse. This analysis will clearly show the channels through which income and expense flow. For instance, a cost analysis at the end of a fiscal year revealed a deficit of ten cents on each procedure in an important department and there were 29,000 procedures for the year. Searching for the cause of such an effect, it was found that one department absorbed the credits due another department of said hospital.

BEDS! MORE BEDS!

Such is the cry of physicians and surgeons. But it means enlarging facilities for the care of the patients who will occupy these beds. Hospital days are shortened, but operating expenses are lengthened to the deadline of deficits. Home visits are now omitted from the day's professional calendar, so the hospital is forced to expand in order to accommodate the patronage which health agencies offer. Cramped living quarters do not afford a spare room in case of illness; again the hospital is requisitioned for a bed, and no space is mentioned for the bed. In one of our large hospitals the admitting office was requested by phone to receive a patient sent by Dr. So-and-So. The anxious voice of a woman received this reply: "Regret there is not a vacant bed at the moment." Like a flash came the rejoiner: "That's all right; we'll bring a bed."

AND HEALTH AGENCIES?

Yes, these good friends of voluntary hospitals, the health agencies, do keep our beds occupied, but they fail to balance the budget. Hospital service cannot be evaluated in dollars and cents; yet, paradoxically, in a year one of our hospitals contributed nearly $90,000 of service to the patrons of one agency. When that agency puts on its yearly drive it omits including in its advertising the contribution of hospital service given without charge by that hospital to the agency's patrons. The government pays full coverage at per diem cost to all hospitals giving hospital service. Why do not other health agencies do likewise?

With the exception of payroll expenses, this per diem cost is based on wholesale prices to the hospital. Take for instance, the meal cost per patient. From the market to the kitchen we record in October a cost of $.3624; from the kitchen to the patient $.2216; the total cost for each meal is $.5840. Compare that with restaurant prices.

Building a 100-bed wing requires the addition of at least 100 employees to your hospital payroll.

URBAN AND RURAL BUILDING ACTIVITY

Owing to increase in population and consequent lack of housing facilities, our large cities must build to meet the demands of the medical profession and health agencies. Formerly, when one was ill, a horizontal posture was in order; but a new schedule has been drawn up and in four or five days the patient takes on a sitting posture, while a late spiritual book announces, "We Die Standing Up." So, there you are!

Especially where there are large industrial plants, hospital facilities should be available to afford immediate relief to the ill and injured. Even a 20-bed hospital in a rural area should endeavor to have the latest and best equipment. Nearness to a large city at times causes delay in building because X-ray, laboratory, and even surgical service may be flown to the patient. Auto accidents on the highways result fatally for want of prompt and available service.

To sum up the building situation, where hospitals are concerned, drastic fire ordinances force hospitals to build or make extensive alterations. True, a building 50 years old, even if of the slow-burning type, would spend many a dollar in rehabilitation, in fact, in some cases it would be more economical to build an entirely new structure.

In this age of medical centers and teaching hospitals, let us give some thought to the building of hospitals for the care of the sick and for the sick poor. A clinic is a valuable asset of any hospital — but in a building apart.

"Sursum corda" should be the watchword of voluntary hospitals that depend largely on Divine Providence to carry them through depression or recession, while we should bear in mind:

"We may build more splendid habitations,

But we cannot buy with gold the old associations."

Local conditions:

The Most Rev. Karl J. Alter

(Continued from page 2)

of the locality and the region which it serves — but also to relate the finding to the plan of hospital and health services in contiguous areas and to the overall plan within the state. By this means it may be possible to integrate the requirements of the locality into that of the state hospital plan with beneficial results to all concerned.

In undertaking the task of evaluating local needs, some or all of the following criteria will be helpful in developing significant factual data.

1. *Population Trends*

Is this community a trading center for the region which it serves?

Is its population increasing or decreasing? If so, does this increase or decrease seem to be permanent or temporary?

If this community is near a trade center or city, what is the influence of this factor on its hospital needs? Is there now a reasonably adequate number of physicians to care for the people in this region? To what extent do the people not patronize these physicians?

2. *Principal and Supplementary Economic Activity*

An important factor in securing and maintaining the financial stability of the new hospital or an addition to an existing hospital, or the introduction of a new service, is the economic activity of the community and the region it serves. This may be industrial, agricultural or a combination of both in one degree or another. The volume of industrial or agricultural activity may vary from time to time with seasonal demand or be subject to other conditions, resulting in a marked increase or decrease in the demand for hospital services. While normal business conditions may be employed to evaluate this factor, it might be prudent to give some thought to the effect of adverse economic conditions.

3. *Local Demand for Hospital Service*

Stimulated by an appreciation of hospital service and what it can mean for the region, many people in the community, including physicians residing there, will urge and promote the development and extension of hospital services in the community.

A number of considerations under this heading will be encountered — and should be studied. These relate, in part, to the following:

a) The educational and cultural level of the people of this community and region should be such that there is reasonable assurance of patronage and support to the proposed hospital program.

b) In the event that there are existing hospitals in the community, the proposal for additional hospital facilities should be undertaken only (1) after a survey of empty hospital beds has been made — and the implications of these conditions are fully determined; (2) after a study of the possible effect, if any, on the patronage of existing hospitals; and (3) where full information is available concerning the present status of the expansion programs of existing hospitals.

Advances in medical science profoundly affect hospital service and sometimes influence or determine the extent of hospital facilities. Early ambulation is one of these factors and should be regarded as an important element in any hospital proposal.

4. *Voluntary Hospitalization Insurance, Governmental and Public Aid*

The devolpment of Blue Cross and other agencies through which the people can finance on a voluntary basis the hospital service they require has achieved significant proportions. It is estimated that about one-half of our population is enjoying the benefits of such coverage.

These agencies include Blue Cross, the hospitals' own organization, other health insurance groups — principally commercial insurance companies, health programs of labor unions — which are developing rapidly — health and hospital plans of Farm Bureau groups and Community Chest organizations. Governmental and public aid agencies are also increasing in the scope of services becoming available under their auspices.

The extent of interest of these agencies in the local community and the region which it serves can be significant determining factors in any new or hospital expansion proposal.

5. *Some Social Considerations*

In addition to other factors which influence people to seek hospital service almost universally, that relating to present modes of housing is believed to be of particular significance. The small homes now so much in vogue and apartment living quarters usually of small size are factors contributing to the greater utilization of hospital service in contrast to home care. These crowded living conditions make it imperative to seek other quarters in which the sick can be restored to health.

Coupled with this condition is the lack of domestic help or of others at home who could be relied upon to care for the sick. While these elements cannot be readily or factually evaluated, they are nevertheless tangible factors motivating many to seek refuge in the hospital.

6. *Medical Factors*

In the present day practice of medicine, the hospital has almost become an indispensable feature. Good medical service, as now understood, implies in large measure the general hospital in which may be found the usual diagnostic and therapeutic aids and equipment. Physicians look forward to having the hospital in which to care for many of their patients.

The absence of hospital service, or inferior service in this area may oftentimes be responsible for the shortage of physicians in a particular community. As an inducement to secure a physician to serve a locality, the provision of hospital services is almost always a requirement of the first rank. This is understandable in the light of present trends in medical education.

Associated closely with the relationship between the shortage of physicians and the need for hospitals is the nature of medical practice, particularly with reference to its complexity. As a result of the many advances in medical science there has come specialization with intensive study of particular areas of medicine. This trend has brought about a better understanding of the ills which befall mankind — but for the hospital and the physician, it means more complex procedures, more extensive equipment, well prepared staff assistants, etc.

Another factor which might be cited as evidence of the growing tendency toward hospital services is the large percentage of obstetrical

patients now patronizing general hospitals. Almost 90 per cent of all registered births take place in hospitals. This trend points to the rapidly growing understanding of the people in the hospital and the part it plays in the life of the average community.

While only some of this section can be evaluated, all of it has bearing on the need for hospital services.

7. *Special Hospital Services*

It has been widely advanced that the present general hospital be extended to provide more fully for certain specialities — including persons suffering from psychiatric disorders, those affected with tuberculosis, and those having chronic illnesses of one kind or another. In many general hospitals at the present time may be found separately organized special nursing divisions for nervous and mental patients and for the tuberculous. In still others, provision is made for the chronically ill. Physicians with special preparations are in charge of these services. Through this concept of the general hospital as a medical center, the people of the local community and the region which it serves receive the widest services available through the community hospital.

Though there are many problems in the development of special services in the areas mentioned above, community hospitals should seek the development of the widest program of service to their people.

In conclusion it may be stated that the utilization of hospital services in the nation as a whole will not decrease in the immediate future. The steady growth of population, the acceleration of hospital insurance coverage, the increasing spread of surgical and medical benefits by a system of prepayment of costs; these and other factors previously mentioned indicate that there still is considerable need of further development of hospital services. Whether or not such a need exists in a given local community is a different question. The latter can be answered only by a careful study of the relevant factors and there a word of caution should be spoken with regard to the amount of debt which is assumed in any building program. The margin of surplus between operating costs and operating receipts seems to be a diminishing quantity as we look into the future.

Too little planning:

J. R. McGibony, M.D.

(Continued from page 2)

included availability of professional personnel, of physical facilities, including medical centers and teaching resources, influences of cultural and educational patterns, of "hospital and health consciousness" of the population, geography, transportation, and communications. In those areas, in the days of development of the philosophy of the Hill-Burton program, there was an average of more than one day of hospitalization per person per year. This required approximately 4.5 beds for each thousand people, which in many instances fell far short of actual need in specific instances.

Figures used in approximating needs for beds for mental and chronic disease patients were far less tangible. Somewhat better estimates were used for tuberculosis bed needs, although practically all experts in that field now emphatically state that the number is inadequate for a really successful control program.

Unfortunately, in too many instances we have become fascinated with watching the scoreboard, and are prone to accept these arbitrary figures as the ultimate in hospital planning.

THE FIGURES SOUND IMPRESSIVE, BUT . . .

While magnificent jobs have been accomplished by some state agencies in realistic planning, some have been content to draw lines blindly on a map and divide their masses of population into thousands and multiply by the magic figures. Both good and poor planning converge into more magic figures of total needs: 255,000 general beds, 310,000 beds for mental patients, 82,000 for tuberculosis, and 248,000 for chronic diseases. Even the accelerated Hill-Burton program can supply less than a quarter of this number. One might glibly say, then, that there is little fear of overbuilding, yet this might be far from the truth in specific areas.

If we can focus more closely on the rules of the game and the ultimate goal of a hospital program we must realize that slide rule manipulation is not the answer. Numbers of beds and proper distribution of beds cannot be secured in the existing hospitals, nor planned for the new hospitals, without thorough evaluation of needs, policies, services, staffing patterns, economy, population indices, and many another factor which helps add up to the need for services and the ability of the local economy to supply those services. Each hospital, each community, each region, and each state must, in turn, be studied as an entity. It is only by such study that we can attain the goal and avoid the perpetuation of errors in location, design, and construction and operation, which are, as someone has said, — "those temples to poor planning, with their mistakes embalmed in concrete and steel."

PLANNING AHEAD IS ESSENTIAL

And such studies cannot be confined to the needs of yesterday or of today, but must be pointed toward the needs of the tomorrows. Increased hospital utilization has been one of the phenomena of the past decade. Little more than that number of years ago less than eight million patients were admitted to hospitals. Last year more than sixteen million patients were in hospitals. In the same period births jumped from 700,000 to 2,700,000. With ever-increasing health and hospital consciousness of the public, can we expect the demand to grow less?

The demand for hospital care is growing so rapidly in some areas that an immediate evaluation must be made. Haphazard methods won't do. No longer can the average hospital, and particularly the small one, afford to have half its beds vacant almost half the time, largely because

The 1950 Convention

Under the patronage and by the invitation of His Excellency, the Most Rev. Moses Kiley, S.T.D., Archbishop of Milwaukee, the 35th Annual Convention of C.H.A. will be held in that city, June 12–15, 1950.

it is not geared to furnish the standard of services which the patient needs and has the right to expect, or which the local economy can support.

In many instances, such conditions can be corrected or improved by proper programs of bed utilization, such as patterns for admission of non-emergency cases, of early ambulation and home care programs, by educational efforts directed toward the governing board, the medical staff, the administrative staff, and the public.

FEWER PATIENTS INSTEAD OF MORE BEDS?

Study and application of sound principles of good out-patient services will play a large part in fulfilling a community responsibility, and in producing a part of the answer to the question whether we are overbuilding — for, as has been said, perhaps we need fewer patients as much as we need more beds. Coordination of activities with other hospitals and resources in the area is a necessity in the truly successful hospital.

All of these things require good planning and intelligent administration. However, they might make two beds serve where three might be built, reducing the costs of construction, equipment, and maintenance tremendously for that community, and allowing another bed to be placed where it is more needed.

A major factor in provision of good hospital services is our foresight and ability to strike the happy medium between an expanded building program and a progressive management program. Good judgment in this respect should make it possible to use wisely all of the beds that can be constructed within the next few years. We must keep pace with the needs and desires of the public within the limits of the national economy.

All of us in the hospital and health field have a moral, and in many instances, a legal obligation, to assist in proper planning, placement, functional design, and efficient administration of hospitals, leading to better patient care. Without this thorough and realistic approach, we may not be accused of *building too much*, but we will be subject to severe indictment for *planning too little*.

Hospital construction

New survey shows trend

A. UNITED STATES

A year ago, a survey was made by the Catholic Hospital Association in order to assemble information concerning new construction which was under way or being planned at the end of 1948.[1] Through this study, for the first time, the influence of The Hospital Survey and Construction Act (Public Law 725) in the development and modernization of existing hospital plants could be measured. Public Law 725, (now known as Public Law 380), providing Federal funds for hospital construction in areas with insufficient hospital facilities, has been a great incentive in the construction program of Catholic and non-Catholic hospitals.

The survey of December, 1948, was made by the questionnaire method directed to the Catholic hospitals and information given by state agencies for hospital construction. Data referring to 410 Catholic hospitals revealed that 127 of them, or 31 per cent, had no construction program under way or planned, while 283 hospitals were in the process or planning new construction or modernization, involving 299 different projects with a total cost of $218,834,000. Thus the average capital outlay for construction per hospital contemplated in last year's report amounted to $774,000.

It was found, furthermore, that an almost equal volume of construction was done, or planned, with and without the aid of Federal grants ($116,371,000 and $102,463,000, respectively).

AVERAGE CAPITAL OUTLAY BASICALLY UNCHANGED

The survey of December, 1949, which is based on reports from Catholic hospitals, solely, shows not much change in the average capital outlay for construction, and in the relation between projects aided by Federal grants and those carried on by the hospitals and local communities alone.

The number of hospitals submitting answers to the questionnaire pertaining to the status of construction at the end of 1949 has decreased to 328, compared with 410 of a year ago, which is regrettable inasmuch as it does not afford a reliable estimate on the total volume of all construction projects of Catholic hospitals. The answers received do not, on the other hand, constitute an unbalanced selection of hospitals which reported

[1] K. Pohlen: A Better Catholic Hospital for '49. HOSPITAL PROGRESS, January, 1949, pp. 1–3.

The $500,000 addition to Sacred Heart Hospital, Lamar, Colorado, which was recently completed, contains a new service floor and a maternity division, and has increased the capacity of the hospital by 63 beds. The institution is operated by the Sisters of the Third Order of St. Dominic.

continues apace

Dr. Pohlen, Director of Research and Statistic of C.H.A. until October 31, 1949, is now engaged in a service of hospital management analysis for a number of Catholic hospitals.

Kurt Pohlen, Ph.D.

Cut shows the new addition to the beautifully located Sudbury General Hospital, Sudbury, Ontario, which is operated by the Sisters of St. Joseph of Sault Ste. Marie. Architect was Louis N. Fabbro.

construction projects under way or planned.

Glancing through the pages of HOSPITAL PROGRESS of 1949, we find numerous notes in the columns of "Hospital Activities," reporting the laying of cornerstones, dedication of recently completed wings, or other data pertaining to construction and referring to hospitals which for one reason or another have not responded. There are a number of hospitals which reported definite construction programs at the end of 1948 and failed to report again for the present survey, and, likewise, hospitals reporting now about construction recently completed which, certainly in process a year ago, were missed in the tabulation at the end of 1949. There are several states in which less than one-half of the projects actually under construction during 1949 could be included in the present survey on the basis of replies to this year's study.

With due consideration of all factors involved, we would commit the least error in taking the 328 replies to the present survey as a representative sample of the Catholic hospitals as a whole. The relative figures, so far as the number of construction projects and their costs are concerned, must be used within reasonable limits.

TAX-SUPPORTED AND NON-TAX-SUPPORTED HOSPITAL CONSTRUCTION

The total number of construction programs reported by 328 hospitals at the end of 1949 is 279, from 38 states, Alaska, Hawaii and eight Canadian Provinces, involving a capital outlay of $163,613,000. For less than one-third of these projects, namely 88, Federal grants (and in Illinois, Kentucky and Mississippi also state grants) have been made or application filed; while 191 projects, or more than two-thirds, are being constructed or planned without the benefit of Federal (and state) grants.

There are several reasons why construction programs are not aided by Federal grants.

a) The hospital area does not have a sufficient priority of need for hospital facilities. This is the case in almost all construction projects concerning hospitals in large or medium sized cities where some acceptable hospital facilities already exist. After areas with highest priorities are satisfied, construction in areas with lower priorities will become eligible for Federal grants. The tempo of construction in urban areas, at least so far as Catholic hospitals are concerned, might come to the point that most of their projects are completed without Federal aid when the area will become eligible for grants several years hence.

b) Modernization of the plant and replacement of expensive items of equipment are often done by hospitals not knowing that even such apparently minor projects may be eligible for Federal grants if the

TABLE 1. Reported Construction Projects of Catholic Hospitals in the United States With and Without Federal Grants at the End of 1949

(The amounts of estimated construction costs are given in thousands of dollars)

Status of construction	All construction projects reported		Construction projects involving Federal grants		Construction projects not involving Federal grants	
	No.	Total amount of costs	No.	Total amount of costs	No.	Total amount of costs
Construction recently completed	89	$ 20,544	4	$ 6,283	85	$14,261
Construction in progress	76	71,292	39	48,766	37	22,526
Start of construction pending	69	42,328	28	22,972	41	19,356
Project in stage of planning	45	29,449	17	13,046	28	16,403
Total	256	$163,613	88	$91,067	191	$72,548

Catholic hospitals across the country either have finished or are about to build new structures. The above are, L. to R.: St. Joseph's Hospital, Menominee, Mich. (Sisters of the Third Order of St. Francis, Peoria, Ill.), Holy Cross Hospital Nurses Home, Salt Lake City, Utah (Sisters of the Holy Cross), and Incarnate Word Hospital addition, St. Louis, Mo. (Sisters of Charity of the Incarnate Word).

hospital area falls within the favored priority group.

c) A considerable number of Catholic hospitals seem to be afraid that the acceptance of Federal grants for construction would involve governmental interference in the administration of the hospital. It should be made clear, that Public Law 725 (now known as Public Law 380) does not authorize government interference in the administration of the hospital after completion of construction.

d) A number of projects were started before The Hospital Survey and Construction Act came into effect. If those projects would have started at a later time, a certain percentage of them would have been eligible for Federal aid.

The latter category is evident in the distribution of construction projects aided by Federal grants and not aided by them which were recently completed during 1949. Among 89 reported projects in this group, only four projects, involving $6,283,000, received Federal grants; while 85 projects, involving $14,261,000, were carried without assistance of Public Law (725) 380.

The situation is much different with regard to the projects which were in progress at the end of 1949. In this category are included those projects in which the construction is actually in progress and those which received the final approval and authorization for Federal aid and are virtually prepared to start. Among 76 projects in this group, practically as many are aided by Federal grants (39), as are being managed without governmental aid (37). The construction costs of the aided projects are $48,766,000, more than twice as high as the construction costs of the unaided projects which amount to a total of only $22,526,000.

The present survey includes a third group consisting of those projects in which the start of construction is pending, depending on the outcome of the approval of the application for Federal grants or the result of a community fund drive presently under way. In each case there is the definite intention to start during 1950. This group contains 69 projects, 28 of them applying for Federal funds, involving a total capital outlay of $22,972,000, and 41 projects not asking for Federal funds, involving a total capital expenditure of $19,356,000.

100-Bed Addition Planned to St. Mary's Hospital, Winfield, Kansas

Announcement of a 100-bed addition to St. Mary's Hospital, Winfield, to cost over one million dollars, was made recently by the Sisters of St. Joseph. Plans for the addition, to be built along the east side of the present hospital building, are now in the hands of the architects.

The Sisters of St. Joseph of Wichita are fostering a building program which will affect six of the ten hospitals operated by these Sisters, and the Winfield institution is one of these six.

The new building, in addition to providing 100 beds for patients, will also provide the hospital with adequate diagnostic and therapeutic facilities. Regular capacity of the hospital is 55 beds. With the new addition, which will be five stories high, the hospital facilities will be tripled, while the staff will increase accordingly.

The last group refers to those projects which are still in the stage of planning, where definite plans are made up, but where this plan depends on several conditions. It is rather improbable that more than a few of them will be realized during the oncoming year. Among them belong projects for which grants-in-aid, asked in the past two years, were refused due to low priority ratings and where the hospital, certainly needing the additional facilities, is not able to provide construction without substantial aid.

INCREASE IN HOSPITAL BEDS

The total construction projects under way and planned at the end of 1949 will improve Catholic hospital facilities in two ways: it will (*a*) provide for better hospitals, replacing old plants with new buildings and modernizing where advisable, and (*b*) increase the number of beds now available. The 1949 Directory of the Catholic Hospital Association reports a total of 114,914 beds, excluding bassinets, in the 806 hospitals in the United States proper. The 279 construction projects afford a net increase of hospital facilities of more than 8,000 beds, adding in

category (*a*), construction projects recently completed	1,194 beds
category (*b*), construction in progress	3,878 beds
category (*c*), start of construction pending	2,072 beds
category (*d*), project in stage of planning	930 beds

The number of beds in obsolete buildings to be replaced by new buildings or additions amounts to at least the same number. Projected on all buildings of all 806 hospitals, this would mean a construction program

of not less than 25,000 beds, divided about equally into new additions and replacements of obsolete facilities.

Not counted are the large number of auxiliary facilities being added or replaced, such as nurses' homes, student quarters, diagnostic and therapeutic facilities, accommodations for Sisters, etc., which often represent a substantial modernization of the hospital plant.

B. CANADA[1]

The tabulation of construction projects of Catholic hospitals in Canada is being done for the first time this year. Only 48 hospitals in eight Provinces reported on the status of construction, 20 of them having nothing to report and 28 giving details on 43 different projects, involving a total of $19,000,000.

The nine structures which were recently completed were, without exception, financed by the hospitals without dominion or provincial funds. This is the same experience as in the United States where very few projects aided by Federal funds were completed during 1949.

Contrary to the situation in the United States, the Canadian Catholic hospitals seem to make more ready use of governmental aid for hospital construction, either in progress or pending. Among 32 projects not completed by the end of 1949, the large majority (23 hospitals) applied for governmental funds while only 11 are going to carry the financial burden alone. In these three categories, the amount of costs, partially financed by the government is many times higher than the amount financed by the hospitals alone, see Table 2.

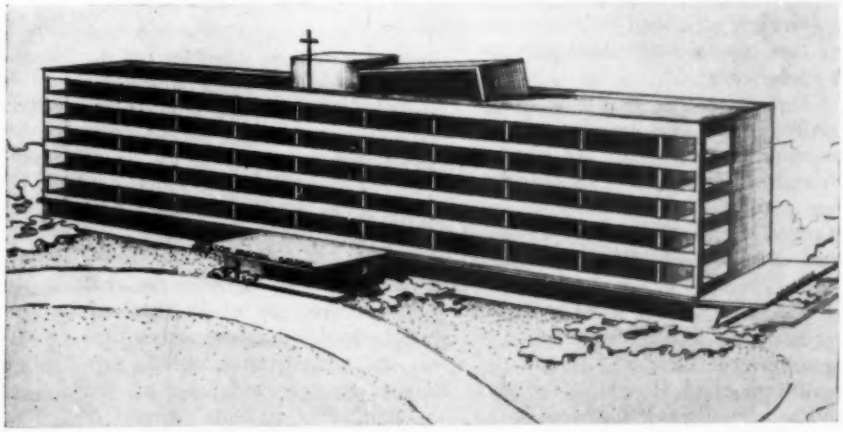
[1]Amounts of costs are given in Canadian dollars.

The large new addition to St. Anthony's Hospital, Amarillo, Texas, operated by the Sisters of Charity of the Incarnate Word.

TABLE 2. Reported Construction Projects of Catholic Hospitals in Canada With and Without Dominion Grants at the End of 1949

(The amounts of estimated construction costs are given in thousands of Canadian dollars)

Status of construction	All construction projects reported		Construction projects involving dominion grants		Construction projects not involving dominion grants	
	No.	Total amount of cost	No.	Total amount of cost	No.	Total amount of cost
Construction recently completed	9	$ 2,221	1	$ 675	8	$1,546
Construction in progress	18	10,080	15	10,007	3	73
Part of construction pending	5	4,310	4	4,305	1	5
Project in stage of planning	11	2,367	5	1,813	6	554
Total	41	$18,978	25	$16,500	18	$2,178



A modernistic note is supplied by the Jackson Memorial Hospital, Jackson, Miss., to be operated by the Sisters of the Third Order of St. Dominic.

Knowing the facts pays off in renovating

Sister Inez

Are you faced with the need of modernizing or expanding your hospital today? Are you limited as to space? To finance? The problem of change in any organization is difficult, but when changes must be made within restricted bounds whether physical or financial, the problem becomes more complex.

Too often, the subject of modernization or expansion causes the administrator to think in terms of the external solutions of the project, such as the selection of building sites, engaging architects and contractors, poring over blue prints, and all the many details involved in the erection of additional floor space. But, do we think in terms of questions like these:

1. What are the needs of our hospital?
2. Who has suggested expansion and/or modernization?
3. Why was the suggestion made?
4. Have we the facts to substantiate the need?
5. Are we using our present facilities to their fullest effectiveness?
6. Have we adequate general statistical information to determine where expansion or modernization should begin?
7. Do we have departmental statistics which will enable us to make a reasonable forecast that expansion or modernization can be profitable as well as desirable?
8. Will our statistics enable us to solve any problems which may arise from expansion or modernization?
9. How will the benefits, gained through expansion or modernization, compare with the cost of the program?

The above nine questions necessarily demand that the administrator examine her present organization from within before actually considering plans for modernization or expansion. Perhaps you will ask yourself at this point "Where does one begin"?

The best possible point at which to begin the internal examination of your present structure, its facilities, and its methods is right in the office of the administrator. Can you, at this moment, put your hand on your hospital's organizational chart? Does that chart show you every department and the level of every position in each department? Have you a physical layout chart showing the location of all equipment and supplies in each department? Have you a departmental work flow chart showing the progress of the work done there?

The author is administrator of St. Mary's Hospital, Rochester, N. Y., and an authority on careful planning in building.

The administrator who not only possesses these charts, but who frequently reviews them, can say with accuracy that she knows the work, the methods and the personnel in her organization. She will know whether the work methods, the equipment, or the personnel are the cause of any substandard performance. Equally important, she will be able to discuss, on an equal footing with her department heads, all major problems arising in the departments. Further, she will be able to evaluate the performance of her co-workers.

When the problem of expanding and modernizing arises, she will be familiar with, and have up-to-date information concerning, the status of any department which may be involved in the program. The administrator who has only the organization chart — or only the work flow chart — or only the organization chart — or any combination of two charts or plans, is not fully equipped. All three are equally important and dependent on each other for full information about the work done in the hospital and they provide the basic material with which to start the modernization or expansion processes.

PATIENT STATISTICS ARE NEEDED, TOO

The next step of your internal study concerns the service rendered, or to be rendered, to the patient. Are you, the administrator, able to produce the statistics which will tell you the number of patients serviced in the medical, surgical, obstetrical, pediatric and new born areas of your hospital? Have these statistics given you a complete breakdown as to the rapidity with which patients pass through these areas? Do your statistics give you the accurate picture of which one or more departments fail to meet the operating cost? Do they tell you what division can expect a greater or lesser activity during a particular season of the year? From your statistics, can you determine whether your medical staff is well balanced? Can you determine if the medical staff can assist in solving the problem of unbalanced occupancy? The administrator who has available, one up-to-date volume of statistical information broken down so that it will reveal not only the numbe. of patients, but also the sex, length of occupancy, type of case, accommodation provided and services used will have the necessary patient statistical evidence to guide her in determining where to begin her expansion. This information will reveal:

(a) Patient statistics
(b) Financial statistics
(c) Comparative statistics

Assume for a moment that you have been forced to turn away patients for lack of bed area. Your community is growing, you can obtain more space only by building. Also assume that you have made your decision to erect a new wing with additional space for 100 beds. Your problem is not completely solved, for here are a few questions which still must be answered:

1. Are you heating your hospital from an old boiler plant? If so, will it carry the additional load?
2. Will you have to add to your professional-technical-clerical-skilled-unskilled employees?
3. Can you accommodate them in the present rest room and the locker areas?
4. Is the dietary area adequate for serving this additional number of patients?
5. Will the X-ray, laboratory, surgery and laundry facilities be adequate to service these additional patients?

6. Will your teaching program be extended thus requiring more space in teaching areas?
7. Will the additional income substantiate the cost of the expansion?
8. Knowing that each patient generally has two to four visitors daily, are you prepared to handle this increase in the visitors' waiting areas?

The administrator who has properly prepared and used her organizational and patient statistical material, will not find these questions difficult to answer.

SAMPLES OF ECONOMIZING ON MODERNIZATION

Let us examine, now, several examples of modernizing a hospital with the minimum amount of building.

Imagine that you, the administrator, have provided yourself with the factors mentioned. Also imagine that you have had trouble in the boiler room. Frequent repairs have been necessary and you would like to replace old or inadequate boilers, but the cost is prohibitively high. Must you worry along with the old one? Must you constantly be faced with the probability of a breakdown? One way to keep cost down considerably would be to investigate the possibility of purchasing steam from a local utility firm, thus eliminating the cost of a new boiler room and equipment. Now your knowledge of the boiler room, its equipment, the flow of work within, and the personnel involved, plus the statistical information at your command, enable you to discuss the matter intelligently with the proper officials and to evaluate the advantage of the purchase of heat over the costly installation of new facilities.

Or, suppose that you, the administrator, have been harassed constantly by department heads pleading for more space; you recognize that they are in dire need of this additional area and that some remedial measures must be adopted. "But," you ask, "where is the best point at which to begin the most beneficial and least expensive corrective action?" Perhaps it might be well to focus attention on the purchasing and stores system. Does the administrator know how much area is given over to the storage of supplies and equipment? By centralizing this department you might gain floor space. It may be that valuable areas are being taken up by storage of slow moving items or obsolete equipment. If every foot of floor space is made as productive as possible with emphasis on utilization you may gain area from one department to alleviate overcrowding in another department. Once more your organizational and patient statistical data will help you reach the solution of the problem.

Again, attention may be directed to the modernization of the oxygen therapy department. Does the administrator realize how much space is required for storage of oxygen cylinders in the hospital? Does she appreciate how much time and effort is expended in transporting the cylinders from the time they are brought into the hospital until they are placed back in the vendors' hands? If the installation of piped oxygen is at all possible, will it not eliminate using space which can be turned into more productive use? Your answers will become clear as you refer to the tools of organization and patient data available to you.

It is proper at this point to review some tangible and intangible benefits which may be gained from the examples just cited.

The first example, that of illustrating the benefits that may be derived by purchasing a service from an outside source, possesses:

a) The elimination of the purchase and installation of new boiler facilities.
b) The elimination of the purchase and storage of coal.
c) The elimination of need for licensed firemen.
d) The elimination of the smoke nuisance in the community and hospital proper.
e) The elimination of the handling of ashes.

The second example of centralizing the purchasing and stores responsibilities offers:

a) Controlled requisitioning and delivery of supplies.
b) Definite lines of responsibility for requests of purchases.
c) Controlled inventory and the processing of invoices through one channel.
d) Systematic weekly or monthly reports from purchasing concerning the assets accounts and the "In and Out" accounts.
e) Lower costs in purchasing through bulk buying rather than small lot purchases.

Finally the last illustration of installing a pipe line oxygen system results in:

a) The elimination of the daily tying up of one or more elevators for the transportation of oxygen cylinders to patients' rooms or to storage areas.
b) More prompt and efficient administration of oxygen to the patient.
c) Vitally important safeguards against fire namely:
   1. The equal of *one* cylinder of oxygen in the entire hospital line at any one given moment under the low pressure of 65 lbs. instead of having 100 or more cylinders each with a pressure of 2200 lbs.
   2. A pipe line which has been tested to carry 1000 lbs. pressure although it is required to carry but 65 lbs.
   3. A pipe line and pipe joints which have a melting resistance point of 800 degrees of heat.
d) The elimination of accidents and injuries to employees due to falling cylinders.

CONCLUSION

While emphasis has been placed upon the gathering of knowledge concerning the organization of the hospital personnel and upon the statistical information of patient flow, it is not presumed that, of themselves, they will solve the problem of to build or not to build. Every administrator properly desires to equip her hospital with the most modern, most efficient and most economical facility to better serve the patients. However, the suggestion is put forth that the decisions of when to build, where to build, how to build and why to build, will be more readily forthcoming when the administrator can reach into her own desk and take out well-thumbed copies of her organizational chart and patient statistical data. You can be sure she will know every phase and detail of the hospital's affairs from first hand study and discussion. You can be certain she will know how to modernize and expand her hospital with the minimum amount of building.

Effectively fireproofing old hospitals

George F. Hutter

A grave problem confronting the administrators of long established hospitals today is the condition of the earlier units of their hospital plant, both from a point of obsolescence and of combustibility. In many cases, the older — and frequently non-fireproof units — are vital connecting links between modern, fireproof structures. How one hospital solved this problem and converted two buildings erected in 1909 and 1918 into modern, fireproof components provides an interesting story.

The Sisters of the Sorrowful Mother established St. Joseph's Hospital, Marshfield, Wisconsin, in 1890. Two of the several additions which had been built over the years — the 1909 and the 1918 additions (Figure 1) — were still in service in 1946 and provided space for many of the important departments of the hospital.

The 1909 building had wood joists, wood floor construction, wood furring and wood lath on all of the corridor walls on the ground, first, second, and third floors. There was wood furring and wood lath on all exterior walls. The open stairway from the ground floor to the fourth floor was of wood. The entire fourth floor and attic was of wood construction, as was the construction of the roof and dormers.

The 1918 building — five stories and attic space — was of reinforced concrete construction to the roof. The roof was of wood construction. The dormers were of wood. The walls of this building were not furred. There was a considerable heat loss resulting from the wood roof construction on both of these buildings.

How St. Joseph's Hospital, Marshfield, Wis., was modernized and fireproofed is described by the president of the Hutter Construction Company.

THE PROBLEM: FIREPROOFING WITHOUT SERVICE INTERRUPTION

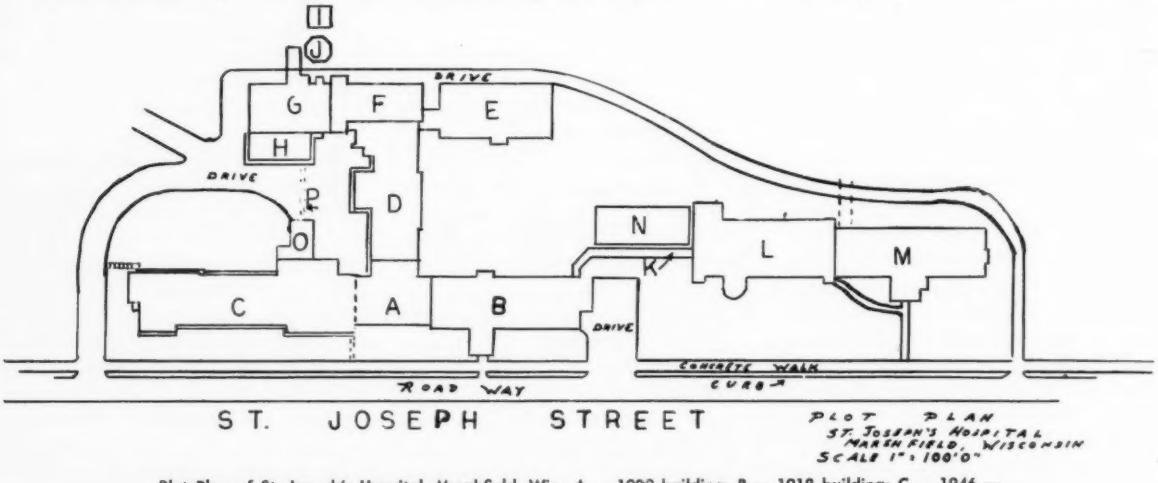
The problem was to replace this highly combustible construction with fireproof and fire resistant construction without depriving the Sisters of the use of the corridors on the ground, first, second, and third floors. These corridors were arteries along which flowed the burden of the traffic to the nurses' dining rooms, the cafeteria, the main kitchen, the special dietary laboratory, and the administration department on the ground floor. The main entrance to the hospital was located on the ground floor of the 1918 building. The corridors on the first and second floors of the 1909 building connected the 1918 building, the 1935 building, and the new 1946 building.

The problem was presented to the Hutter Construction Company, Fond du Lac, Wisconsin, which company was then engaged in the construction of the new north wing addition.

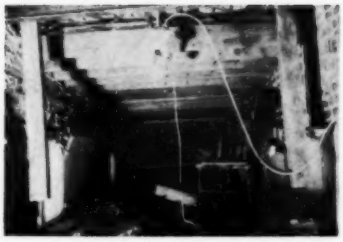
The first consideration was to provide fireproof supports for the entire floor construction of the 1909 building by means of the insertion of a steel frame which would be encased in concrete. The program was complicated by the fact that it was imperative that the connecting passageways and corridors be available for the owner's use at all times. It was decided to use air-tight, dust-proof passageways in the corridors which would permit fireproofing operations to be carried on above and below the floor that was being used as a passage until work in that area had progressed to a point where the temporary enclosures could be removed.

WHAT HAD TO BE DONE

The 1909 building had an open wood stairway at the intersection of the principal corridors. The construction was wall bearing with wall bearing corridor walls up to the third floor. The heavy wood construction was supported on a timber frame with



Plot Plan of St. Joseph's Hospital, Marshfield, Wis.; A — 1909 building; B — 1918 building; C — 1946 — new north wing; D — 1935; E — 1907 building — convent wing; F — 1907 building — chapel; G — 1918 — building boiler room and laundry; H — 1947 bulding — laundry addition, I — pump house; J — 1949 — new stack; K — 1941 — passage to nurses home; L — 1941 building — school of nursing, nurses residence; M — 1921 building — original nurses home rebuilt in 1941; N — tennis court; O — 1946 building — ambulance entrance; P — 1946 — tunnel to boiler room.



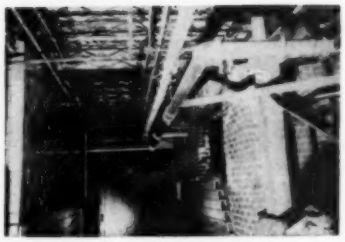


Fig. 2 (left) shows one of the corridors with wood joists; a steel joist is in place in the foreground. Fig. 3 (right) illustrates the ceiling of the ground floor corridor with bar joists in place.

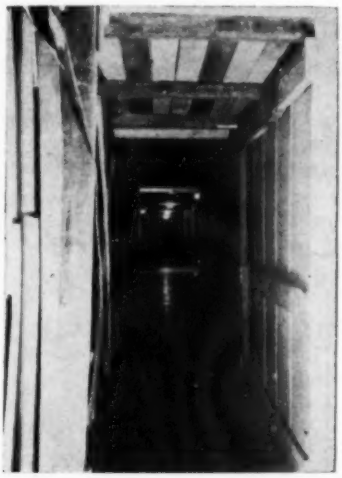
heavy wood purlins and wood rafters. Since it was imperative that construction operations be carried on without interfering with at least partial use of this important "T" unit, the roof had to be kept intact. Careful study suggested placing a structural steel frame inside of the building. This structural steel frame was supported on new reinforced concrete footings placed below the ground floor. The structural steel members were extended inside of the corridor walls with steel beams at all floors, arranged to take the loadings of the new reinforced concrete fireproof encasements of the structural steel members, the concrete slabs, the terrazzo floor, and partition loads. As this steel frame was being placed, the work was carried on through the windows, using an outside scaffold, and the corridors were kept open for traffic.

Terrazzo floors with rubber tile runners had been placed in the corridors of the 1909 building on the ground, first, and second floors in 1935, replacing linoleum covered wood floors. These corridor areas were supported with wood joists bearing on brick load-bearing corridor walls. The wood joists were replaced with steel joists, using the exact center. As a wood joist was removed, a new steel joist was inserted and held in position with screw jacks until the bearing of each steel joist was securely wedged in place with steel shims, and grouted.

Figure 2 illustrates one of the corridors with wood joists and shows one of the steel joists in place in the foreground. Note the knob and tube wiring which was encountered.

Figure 3 illustrates the ceiling of the ground floor corridor with bar joists in place and also shows the new structural glazed tile being placed on the corridor walls.

Figure 4 shows a dust-proof corridor enclosure with the new 1946 building in the distance. These dust-proof partitions made it possible for visitors and hospital personnel to travel to the three important units previously referred to, without interfering with the construction activities. The partitions were placed in such a way that all work in the corridors could be carried on behind them. There are new plastered walls and acoustically treated ceilings in all of the corridors.



The possibilities of fireproofing existing structures and "by-product" advantages are graphically illustrated in the photos above and below. Top cut shows the dust-proof corridor "jacket" which made it possible to continue using the corridor. Bottom cut shows the amount of damage done by water over the years — damage which was unsuspected.

WHAT HAPPENS "BEHIND THE SCENES"

The condition of some of the masonry found in the angles of the 1909 and 1918 buildings tells its own story. The deterioration of the masonry shown in Figure 5 was caused by water continually backing up as the result of freezing and thawing which eventually burst the gutter. In some cases, water had backed up into the roof as much as five feet.

Figure 6 illustrates the new bar joists in place in one of the corridors.

In planning the construction work, great care had to be taken not to disturb the principal service lines, many of which originated in the 1909 building and which had to be supported and held intact until new facilities could be provided for the important mechanical lines, particularly the electrical service.

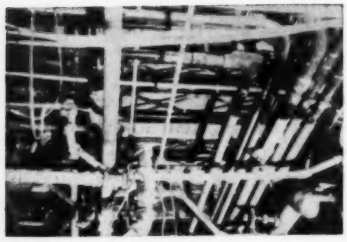
Figure 7 illustrates what was encountered under one of the utility rooms. All of this piping was previously supported by wood joists.

Figure 8 shows an open room area with steel columns and beams encased in concrete. Clay tile partitions replaced wood stud and wood lath partitions.

Figure 9 illustrates the removal of the wood construction of the roof and dormers. A great deal of damage to the masonry was caused by the failure of the large metal gutter.

Figure 10 shows the importance of a water-tight temporary roof to pre-

Fig. 6: the new bar joists in place in one of the corridors.



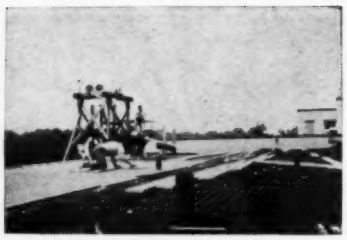
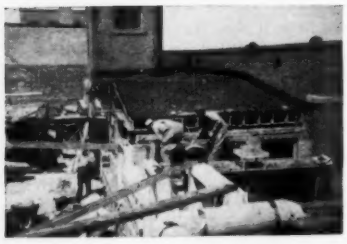


Fig. 12 (left) shows the metal lath which supports the concrete roof slab, and Fig. 13 (right) shows a section of steel stairway being hoisted into position with the aid of a swinging derrick.



Top to bottom: Fig. 7: wood joists used to support this piping; Fig. 8: clay and steel replace wood stud and lath; Fig. 9: removing the wood construction of roof and dormers; Fig. 10: a water-tight temporary roof was installed; Fig. 11: structural steel in place to support the new roof.

vent damage to the occupied portions of the buildings below.

Figure 11 illustrates the structural steel in place to support the new roof. The large water main which is the main distribution line for the hot water system was supported and kept in operation all during the period of construction.

Figure 12 illustrates the metal lath which supports the concrete roof slab, with the concrete slab being placed.

It was necessary to raise the structural steel members on the outside of the buildings and to lower them into position with the use of swinging derricks. Figure 13 illustrates a section of steel stairway being erected.

Reference has already been made to the fact that the 1909 building was of wall-bearing construction and the 1918 building was of reinforced concrete construction to the roof. The owners wished to place an additional story on the 1909 building but the walls would not support the additional story. Therefore, all of the foundations had to be underpinned with suitable concrete footings with the concrete walls securely anchored to the masonry. The foundations were then faced with native stone.

The fronts of the 1909 and 1918 buildings and the end of the 1918 building were then veneered with face brick to match the brick in the new 1946 building. This operation is illustrated in Figure 14 and shows the scaffolds being erected. The wood roof construction and the dormers were still in place when this picture was taken.

Figure 15 illustrates the scaffolds extended to the roof line of the 1918 building and also shows the steel frame for the new stair tower at the right. This extra stairway was required because of the extra floor space resulting from the additional floor placed on the 1909 building.

Figure 16 is a close-up of the removal of dormer and wood roof construction.

Figure 17 is a view of the front elevation of the 1909 and 1918 buildings with the veneering completed and the scaffolds being removed.

MUCH WORK, BUT CHEAPER THAN NEW BUILDING

After reading this article, one may ask — "Would the owners have been better off if the buildings had been razed and a new building erected?" The answer to that question is a definite "No." If the buildings had been razed, it would have been necessary to arrange for temporary connections for at least three floors, since elevators are located in the 1918 and 1946 buildings and one of the more important elevators is located in the east "T" of the 1909 building.

It was very much more economical to provide for the dust-proof partitions in the corridors, as previously described. In addition, there were many other facilities in use on the ground floor which required little additional construction work. The floor space on the fourth floor of both buildings was increased by one-third with the removal of the pitched roof and dormers. To have duplicated the floor space provided in the 1909 and 1918 buildings in new construction would have cost the owners very much more, without taking into consideration the inconvenience that they would have suffered through the loss of the facilities contained in the two buildings that were fire-proofed and rehabilitated.

Many of the more important adjunct facilities are now located on the fourth floor, such as the laboratories, the complete X-ray department, special operating and dressing rooms, prostatic re-section and proctoscopic rooms. The 1909 building connects with the maternity department

Fig. 14: Veneering the 1909 and 1918 building to match the 1946 building; scaffolds are being erected.

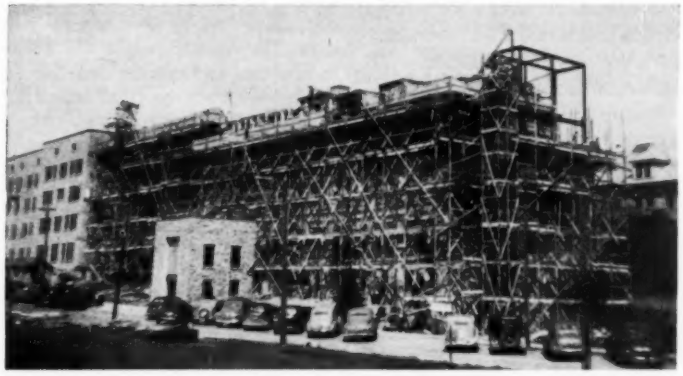


Fig. 15: A new stair tower had to be built to take care of extra floor space resulting from addition of floor on 1909 building.

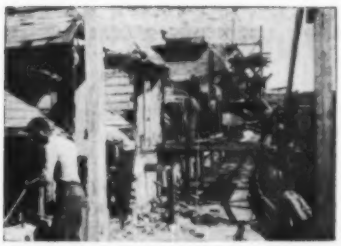


Fig. 16: Shows a close-up of the removal of dormer and wood roof construction.

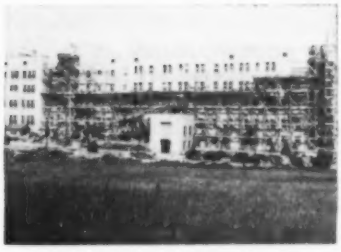


Fig. 17: Veneering on 1909 and 1918 building is complete — scaffolds are being removed.

facilities in the 1935 and 1946 additions.

Figure 18 illustrates the new 1946 building in the foreground to the left and the 1909 and 1918 buildings in the right foreground with the exterior work nearing completion. The buildings at the extreme right are St. Joseph's Hospital School of Nursing and nurses' residence.

An interesting point to note is that the owners had use and occupancy of the ground, first, and second floors while construction operations were in progress on the third and fourth floors.

Fig. 18: Air view shows the new 1946 building in the left foreground; 1909 and 1918 buildings are in the right foreground. At the extreme right are the school of nursing and nurses residence.

Planning a new heating plant to save fuel

Charles F. Neergaard

Hospitals are overheated and often have too large plants, according to the author, a member of the consultant firm of Neergaard and Craig.

A good introduction is, under all circumstances, highly important. A young man who wanted to marry Angus MacPherson's comely daughter opened his interview with "Sir, I'd like to show you how I can save you some money." I am hoping to do the same. These are times which try men's souls — particularly those souls who must find the money to build and operate our hospitals — and in these hospitals the cost of the heating and mechanical plan represents anywhere from 25 to 30 per cent of the total investment and its operation and maintenance bulks large in the yearly budget.

In the average hospital there is no other department which offers such opportunities for substantial and continuing economies as the mechanical plant. In a group of 14 hospitals in the same district, under Greenman MacNicol uniform accounting control, there was a spread of from 7 per cent to 16 per cent of the annual budget for power, light and heat. This department is often the only place where major savings can be effected without sacrificing something needed for the care and comfort of the patient.

HOSPITALS ARE OVERHEATED

Hospitals as an industry have never analyzed their precise needs and formulated definite standards and performance specifications for the different elements of the mechanical services. They are notoriously overheated but I have yet to see or hear of one that did not have heat enough. The consulting engineer takes no chances. In the absence of stated requirements each engineer has provided what he thought the hospital ought to have and there is a surprising difference in engineering thinking. He usually errs on the safe side, with excessive heating capacity, breakdown reserves, automatic controls and refinements. Because it is a hospital he seems to feel that practically everything which art and science have accomplished in mechanics is appropriate. As a result too many of our hospitals have been mechanically overloaded with too large boilers, too much radiation, too many radiators, too much ventilation — all costing too much money.

In designing the heating plant the engineer must consider many factors, largely Greek to the layman. His calculations, among other things, must cover room temperatures, transmission coefficients, infiltration values, wind velocities, exposure and the outside design temperatures.

On this continent of ours winter climatic conditions vary from the low temperatures of 35° below in some of our northern states with long heating seasons, to 35° above zero in our rival winter resorts, Los Angeles and Miami, where on the few cold mornings a flash of heat through the radiators gives all the comfort needed.

THE EXPERTS TALKING

In the 1949 Guide of the American Society of Heating and Ventilating Engineers it states:

"There are no hard and fast rules for selecting the design outdoor weather condition to be used for a given locality, type of building and heating system and the problem is to some extent a matter of judgment and experience."

In the January, 1948, issue of the Society's Journal, Clark M. Humphries, the senior engineer of its research laboratories, commenting on a recommendation that the design temperatures should not be more than 15° above the lowest temperature on record during the last ten years suggested:

"The outside temperature is too important a factor to be determined on the basis of one cold day . . . A logical method of design temperature selection is urgently needed. Without it heating design in hundreds of communities will continue to be based on some unreliable rule of thumb."

One might get the impression that many of our hospitals have suffered from these "rule of thumb" designed heating plants.

Mr. Humphries further suggests — and we can heartily concur:

"Any heating system that is oversized is difficult to control and causes more discomfort than a smaller system will cause on a few extremely cold days. The smaller system will be lower in first cost and operate more efficiently throughout the heating season. The daily minimum temperature usually prevails for such a short time that with the heat storage within the structure its effect on the heating load is negligible."

I have long been fortunate in an engineer associate, Mr. C. E. Daniel, whose approach to his job is best exemplified by his frequent announcement "I have found another way to cut my fee." His is the simplified concept of the hospital heating and mechanical plant which I am describing here. In over a score of hospitals on which we have collaborated his plants, radically departing from engineering text books and codes, have functioned practically and economically for 15 years or more. His has been a voice crying aloud in the desolate engineering wilderness.

Many of the ideas which he has developed to simplify, rationalize and reduce the cost of engineering practice for the various elements of the hospital plant are outlined in the Mechanical Section of the "Design and Construction of General Hospitals" recently published by the Division of Hospital Facilities of the U. S. Public Health Service, for which he acted as engineering consultant.

How much of a heating plant does a given hospital need? I have quoted engineering literature which suggests that "the problem is to some extent a matter of judgment and experience"; that "heating design is based on some unreliable rule of thumb." It is frequently stated that given a well insulated building the heating

plant can be cut in half — but half of how much?

HEATING YARDSTICKS WORTH KNOWING

In the original text of the U. S. Public Health Mechanical Section Mr. Daniel set up certain yardsticks which unfortunately were omitted from the final publication. They should be invaluable to building committees and their architects in appraising the recommendations of the mechanical engineer.

"Boiler capacity may be roughly estimated at one horsepower per bed when the heat is figured at zero temperature.

"Two-thirds of the boiler capacity is required for heating and one-third for hot water, laundry, sterilizers, etc. for an uninsulated building.

"When the walls are well insulated the size of the heating boilers and radiators can be reduced approximately 25 per cent: if in addition the windows are effectively double glazed, 50 per cent, — or approximately one square foot of radiation to 160 cubic feet of space."

These ratings are based on many completed projects, not on theory, and however much they may be challenged in terms of "the book", will serve as a rough basis for estimate. Hospitals vary so widely in their content and the number and size of their buildings that suggesting a boiler capacity of one horsepower per bed is open to the same criticism as the commonly used "average cost per bed" figure for construction. Yet we have records of 13 hospitals with a total of 2,800 beds where boilers of one horsepower per bed or less have carried the winter load, with a total capacity, including standbys, averaging 1.4 horsepower per bed. One 200-bed hospital in Prince Edward Island, Canada, operates on one 60 horsepower boiler and another in reserve. A comparison of these figures with six general hospitals in New York City, with 2,900 beds, which have boiler plants averaging 2.6 horsepower per bed, is at least suggestive.

In figuring the ratio of radiation to the cubage of the building there are many uninsulated structures where one square foot of radiation to 80 cubic feet of space has proved adequate for zero temperature. When we come to modern insulated construction engineers vary widely in their allowance for the increased thermal capacity. We have four hospitals under construction where the walls are insulated but where, unfortunately, it was considered by the architects and engineers that double glazing would cost too much. For insulated walls, at zero temperature, one square foot of radiation should suffice for 120 cubic feet of space. Here is what is specified by four different engineers:

Central Pennsylvania, 1 s.f. to 99 c.f., Approximate design temperature –5°.

Long Island, N. Y., 1 s.f. to 70 c.f., Approximate design temperature –0°.

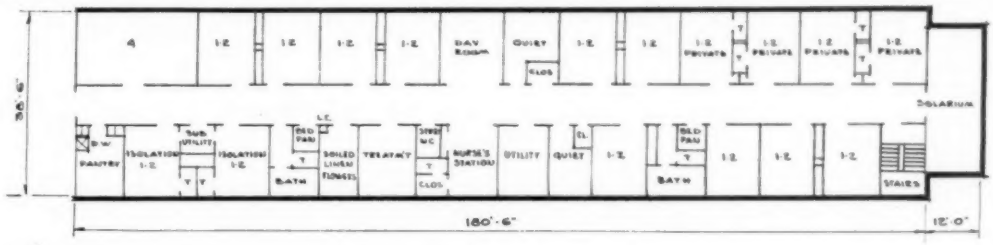
Northern New York, 1 s.f. to 85 c.f., Approximate design temperature –10°.

Central Virginia, 1 s.f. to 47 c.f., Approximate design temperature +15°.

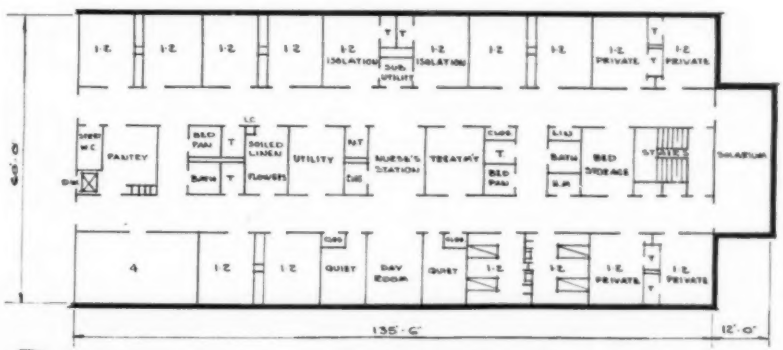
All of these buildings have exhaust ventilation except Virginia which has an elaborate system of forced fresh air. If detailed costs were available they would undoubtedly show that with the generous radiation specified, double glazing would have saved money initially, as well as in operating cost over the years.

WHAT COMPLETE INSULATION CAN ACCOMPLISH

We have two pioneer jobs which were completely insulated — walls, windows and roofs. The Hagerstown Hospital, built in 1936, has one square foot of radiation to 156 cubic feet and the Bethlehem Hospital, built in 1946, using the economical double corridor plan, (see cut), where no direct heat is required in the central service area, has one



A CENTER CORRIDOR PLAN - 38 BEDS
SCALE 1/16" = 1'-0"



B DOUBLE CORRIDOR PLAN - 38 BEDS
SCALE - 1/16" = 1'-0"

COMPARATIVE CHART

PLAN	A	B
FLOOR AREAS & INCLUSIVE OF SOLARIA	6950	8130
AREA PER BED	183	214
INSIDE PERIMETER OF EXTERIOR WALLS INCLUDING SOLARIA LIN. FT.	409	395
DISTANCE FROM NURSE'S STATION TO FARTHEST PATIENT'S ROOM DOOR LINEAR FEET	88	59
NUMBER OF WINDOWS (EXC. SOLARIA) USING SINGLE WINDOWS	29	21
USING 2 PER PATIENT'S ROOM	46	40
NUMBER OF RADIATORS	32	24

Comparative chart shows that double corridor plan needs fewer radiators.

square foot to 200 cubic feet of space. Both of these hospitals have ample heat and confirm the yardsticks ratio that one square foot of radiation in a thoroughly insulated building will heat 160 cubic feet of space at zero temperature.

I have long been recommending that the building committee should exercise the same care in selecting its mechanical engineer as its architect: that he should be appointed and paid by the board, with the approval of the architect, and be a member of the planning body from the start. Too often the architectural plans are substantially completed before the engineer begins his work. Architectural and engineering plans must dovetail. If the architect does not design a tight building the engineer has to enlarge his plant to "heat all out doors". Engineering plans and specifications should be reviewed as they are developed and not, as has too often been the case, when presented in final form. Changes or omissions of part of the system affect all others — the amount of ventilation, the size of piping, boilers, oil burners, etc.

Many times I have sensed that the boilers were too big and that there were too many radiators but had no way to prove it. The engineer always stood up for his design, the architect stood up for his engineer, the trustees said "We can't afford to take chances", and so the oversized plant went in.

BASIC ELEMENTS OF THE HEATING PLANT

I can outline rather simply what in my experience should be provided in a hospital heating plant for maximum economy and comfort:

The building should be fully insulated against heat loss through walls, windows and roof;

It should have a flexible boiler plant to supply steam economically for both the winter and summer load;

It should have a closed system of circulating hot water heat properly zoned, with temperature controls in the boiler room. Panel or radiant heat may well be considered as a desirable alternate;

It should have adequate exhaust ventilation to remove steam and odors, and keep the air in motion;

Certain departments, such as the surgery, delivery suite and nurseries, require special controlled heat, ventilation and humidity and perhaps complete air conditioning.

Insulation from the standpoint of comfort and economy is the most productive investment that can be made in a building. In winter single glazed windows and uninsulated walls draw the body heat to their cool surfaces and cause a chilly feeling even though the air temperature may be 72° or higher. In summer several controlled tests in our hospitals, with recording thermometers, have shown that an insulated building averages 8° cooler than an uninsulated one. Contrary to the general impression of architects and engineers, insulation will not increase the overall cost of the building as the savings which can be made in a properly designed heating plant are sufficient to cover the extra cost of thermal wall furring and double glazing. No one would use less than a tight roof to keep out the occasional rains, and rain is free; yet year after year we keep on building walls and windows that waste heat 24 hours a day, and heat costs money.

Engineers differ widely in the amount of radiation which they specify for similar conditions. The illustrations show the radiation used in a typical patient's room in three of our hospitals. The rooms are of the convertible type for one or two beds and are identical in size, 12 by 15 feet, with nine feet by six inch ceilings. The same Richey-Browne window was used and all buildings had circulating hot water heat. Porchester, an extravagant design, had 68 square feet of radiation and 1¼ inch connections; Yonkers had 48 square feet and three-fourths of an inch connections. Hagerstown, with insulated walls and windows, had 28 square feet fed through seamless copper tubing. The extra cost of wall insulation for this room unit was $18.80 and of the Thermopane glazing $81.00, or a total of $99.80. Three contractors gave us their unit cost estimate for installing a heating plant which ranged from $5.75 to $8.00 per square foot of radiation. Allowing but $5.00, the 20 foot smaller radiator in the Hagerstown room saved $100.00.

We have been using successfully for wall insulation back of the masonry a 3 inch Porex furring block with an integral vapor seal to control condensation. This makes a wall some 300 per cent more efficient in controlling heat loss than all masonry construction. The blocks which have an excellent plaster bond are 20 inches wide and 80 inches long and are laid up by the mason in a third of the time needed for split tile furring. In windows we have used Thermopane, Twindow, or other effective double glazing.

One example will suffice to indicate the low cost of operation. In 1947 a 547-bed hospital in Canada with only half of its building insulated spent $40,600 for power, light and heat while a 520-bed hospital in New York City, uninsulated, spent $163,000.

A FLEXIBLE BOILER PLANT

Most engineers have provided in their hospitals two high pressure boilers each sufficient to carry the winter load. This entirely disregards the fact that summer steam requirements are but one-third those in winter, for domestic hot water, kitchen, laundry, sterilizers, and occasional heating of operating and delivery rooms. This means that during five or six months of the year a large boiler will be operated uneconomically at a fraction of its rated capacity. Modern boilers run most efficiently at 125 per cent or more above their rating and are extravagant when operated at less.

The most economical boiler plant for a 100-bed hospital would be one 70 horsepower steel hot water heating boiler and two 40 horsepower 125 pound boilers, which would save 50 horsepower as compared to the usual provision of two 100 horsepower high pressure units. The hot water heating boiler costs less than the high pressure. It can be reconditioned in summer. The maintenance charges are lower as it will not corrode and requires no pumps. In the event of a winter breakdown the two high pressure boilers at 125 per cent rated capacity can carry the entire load, a hot water converter being provided for the heating system. Should the engineer prefer to use high pressure steam for heating, three boilers of equal size are better than two.

Most engineers seem to favor a high vacuum heating system which theoretically draws warm vapor through the radiators in mild weather and provides high temperatures when needed. However, if some of the traps fail to work or there is a leak

in the lines the vacuum is lost and the system takes on all the characteristics of steam, with radiators all hot or all cold. To the best of my knowledge I have seen but one vapor system in a hospital which lived up to the claims made for it. The operating engineer simply does not keep it tuned up.

In our experience a closed system of circulating hot water heat is by far the most satisfactory for a hospital. Comfortable low radiator temperatures are easily maintained and in extreme weather the circulating water can be raised to 210°. It is the most economical to install and maintain. If the building is properly zoned the heat needed for the different exposures can be controlled effectively in the boiler room.

Panel heating with pre-fabricated coils in the ceiling, represents the best system for hospitals. This is widely used in England and appears to be the ultimate ideal. Warm water around 120° circulates through the ceiling coils and heats the room surfaces instead of the air. It is clean, healthy and in English experience uses 30 to 40 per cent less fuel than steam. There are no dirt catching radiators or dust bearing air currents to soil walls and draperies. An engineering report on 42 English hospitals covering 15–20 years of experience, with an aggregate of 232 heating seasons, shows no leaks, no repairs, and negligible discoloration or cracks in the ceiling. Control of water temperatures in the boiler room has proved sufficient, warmth was equally distributed and comfortable temperatures maintained. Most American engineers seem to be of the opinion that panel heating will cost from 25 to 30 per cent more to install than radiators. We have recently let a contract for a small hospital in Rhode Island where, thanks to the ingenuity and team work of the structural and mechanical engineers, we have a design, with the heating coils in a thin concrete floor slab, which saved $10,000 over the alternate bids for radiators.

Mechancial ventilation has for years been one of the hidden leaks in the hospital operating budget. From the elaborate Plenum systems in vogue 30 years ago (and I never saw one working) to the complete air conditioning of today, the first cost and annual upkeep are seldom realized by the building committee. The average hospital needs only effective exhaust fans to remove steam and odors and keep the air in motion. Given plenty of windows a forced fresh air system is rarely justified considering the extra boiler capacity which must be provided to heat the additional air. Many hospitals, when they have found how much it costs to operate the fresh air fans and how really unnecessary the additional ventilation was, have shut down the fans but they still have to pay the standby charge for electricity and overheat the building with the additional boiler capacity.

In a recent job fresh air fans were specified for the basement kitchen and laundry, all well provided with windows. Forty extra boiler horsepower was required to heat the air, which equalled the capacity needed to heat the entire building. If, as is rarely the case now-a-days, a new hospital is located in a congested area where the air is foul, if it has a crowded out-patient department or if local building codes require it, filtered fresh air may have to be introduced in portions of the building.

They say of science that it is always resourceful — when it could not pry open the Pullman windows it air conditioned the train. The engineer frequently endeavors to create ideal conditions in the patients' rooms or wards with controlled humidity, frequent air changes and higher than normal temperatures, all of the elements of complete air conditioning except cooling. The average patient goes to a hospital to recover from pneumonia, have a baby or have his appendix out. He leaves the normal atmosphere of his home and within a few days returns to it. In the study which I made of hospital air conditioning several years ago, after a review of over 100 articles in scientific publications, I found many theories but no convincing factual evidence of the therapeutic value to hospital patients of "man-made weather" aside from the somewhat controversial comfort factor. There is a grave question whether the cost of installing the equipment required to produce these ideal conditions is warranted. We have never felt so.

In the operating suite, where, for efficient work, the surgeon's comfort is paramount, complete air conditioning is common practice. Temperatures must be maintained at 78° to 80°, and relative humidity around 60 per cent, together with adequate air changes to remove odors and gases.

For the highly technical requirements covering "Safe Practice for Hospital Operating Rooms" I would refer to Bulletin No. 56, published in 1949 by the National Fire Protection Association, which covers ventilation, electrical equipment and various measures which must be taken to prevent static spark explosions. The same precautions hold good for the delivery suite.

Given a well designed mechanical plant how well it functions depends on the operating engineer. In the average hospital organization the engineer is responsible for the maintenance of the buildings and grounds as well as the operation of the mechanical plant. The public is more sensitive to a broken shade or peeling paint than to a leaking steam

Dr. Harvey Agnew Resigns to Enter Consulting Field

Dr. Harvey Agnew, Executive Secretary of the Canadian Hospital Council since its inception in 1931 and Editor of "The Canadian Hospital" has resigned to enter the consulting firm of Neergaard and Craig, New York City, which will henceforth be known as Neergaard, Agnew and Craig.

Offices are being opened in Toronto and these will be under the direction of Dr. Agnew, who will continue as head of the course in hospital administration at the University of Toronto. Dr. Agnew will also continue on a part time basis with the Canadian Hospital Council until next June.

Dr. Agnew is a past president of the American Hospital Association and has served on a number of its councils and committees. He was one of the first selections for Honorary Fellowship in the American College of Hospital Administrators. For many years he was director of the Department of Hospital Service of the Canadian Medical Association and is a member of the American Association of Hospital Consultants.

valve or dirty boiler, so it follows that the engineer must give first consideration to the shade and paint while the valve blows steam, and heat from the boiler fires goes up the chimney.

The hospital superintendent takes the power plant as he finds it, hires the best engineer the budget will allow to run it and is satisfied as long as the plant continues to function without shutdowns. He has no yardsticks to measure abnormal deterioration of boilers, pumps and machines as these do not show on the monthly bills. He is not apprised of such damage until the boiler inspector orders a boiler shut down for repairs or a pump refuses to turn over. He knows what the plant cost to run last year and is delighted if there is a saving this year, but how can he determine what it really ought to cost?

In 18 hospitals in one city district annual power, light and heat costs in 1948 ranged from $132 to $425 per bed; fuel costs alone from 35 to 65 per cent of the total. A review of the figures for 10 of these hospitals is interesting, showing as they do the wide spread in what hospitals are paying in the engineering department.

LIGHT, HEAT & POWER
Comparison of Operating Costs
1948

Based on the uniform accounting figures of Greenman, MacNicol & Co., C.P.A.
Hospitals exceeding 200 beds and bassinets

Hospital No.	No. Beds*	Total Cost L. H. & P.	Cost Per Bed	Total Fuel Cost	Fuel Cost Per Bed
1	520	$211,885	$407	$117,344	$226. **
2	493	64,814	132	42,138	85.50**
3	459	190,491	415	77,221	168. **
4	363	65,444	180	25,258	69.60
5	346	145,495	420	63,027	182. **
6	329	77,145	234	28,888	87.80**
7	291	64,080	220	25,859	88.86**
8	285	61,244	215	24,222	85.
9	265	75,604	285	40,801	154.
10	237	58,259	246	31,444	132.67**

* — 4 bassinets = 1 adult bed
** — no charge made for water

In these days of high costs and scarce money conservative engineering which conscientiously studies and determines the hospital needs, and then determines how much is enough, can go far in increasing comfort and reducing costs. In the major part which the heating plant must play, the hospital is well advised to adapt itself to its financial and atmospheric climate.

Is this a good time to renovate?

"Definitely" . . .

says hospital consultant **Jacque B. Norman**

Now is certainly a good time to renovate a hospital. Many new hospitals receive minor renovations before they are fully occupied, an illustration that the alert administrator is improving patient care, improving efficiency of operation, improving patient safety, improving traffic flow or the general appearance of the building and does not necessarily indicate a lack of proper design or construction of the new hospital. Only the field of recently discovered sciences can offer a more changing operation than can medical and hospital care. Constantly to meet these changing conditions and to improve our hospitals is the reason for the opening statement of *"now* is certainly a good time to renovate." Other than the above factors, there are many reasons to renovate during the period 1950 to 1955. Funds for renovation are available under Public Law 725 (Hill Burton Act), various states have made special funds available to hospitals and the public is becoming more public spirited toward hospitals and more liberal with donations to hospital building fund campaigns, as a result of the American Hospital Association's Public Relations Campaign, the local hospitals' public relations campaigns, and the more constant utilization of hospitals.

Basic reasons for renovating hospitals can be classified in three categories. In order of their importance they are:

1. Improve patient care.
2. Improve operation of the hospital.
3. Improve appearance of the hospital.

PATIENT CARE REQUIRES MODERNIZATION

The most important element of any hospital is the patient and the care that the patient receives. To consider renovation for the purpose of improving patient care both from a medical standpoint and hospital service should be the first consideration in any anticipated renovation program. Modernization is essential to keep American hospitals abreast of the ever changing and fast advancing medical care including the new discoveries of drugs, patient treatment apparatus and new techniques for patient diagnosis and therapy. Each discovery and each invention of new apparatus for improved patient care and diagnosis presents a new procedure for the hospital. To renovate a nursing unit for better patient care to meet modern trends in medical and hospital treatment therefore becomes the *first* consideration.

Still to be considered under improved patient care and probably the most serious factor today is the renovation of our hospitals for safety to patients. This is particularly true for fire safety to patients as many American hospitals were built of non fire resistive material and construction. In considering renovation for improved patient care from a fire safety standpoint the following should be included in any renovation program of a non fire resistive building:

1. Automatic sprinkler system.
2. Automatic fire detection and alarm system.
3. Enclosing vertical shafts such as stairways, elevator shafts, etc.
4. Exits — including horizontal exits.
5. Fireproofing present structure.

The early discovery and extinguishing of fires in hospitals is more important to life safety than the confinement of such a fire to any particular area, or the evacuation of patients.

Hospitals constructed of wood

floor joists, wood stud partitions and other similar type non fire resistive construction should first consider an automatic sprinkler system for the entire hospital. Several hospitals in their renovation program recently have been agreeably surprised at the low cost of the installation of an automatic sprinkler system.

AUTOMATIC SPRINKLER SYSTEMS — WHEN AND WHERE

Automatic sprinkler systems may not be necessary in semi-fire resistive construction, however automatic sprinklers should be installed in the more hazardous areas such as linen chutes, paint shops, kitchens, etc. An automatic sprinkler system for these areas with the installation of an automatic fire detection and alarm system, properly connected to the local fire station, is essential in the renovation program to life safety.

Confining a fire to a definite area is one of the best protections for patients safety. In order to give proper protection to patients of any hospital all vertical shafts must be enclosed. Present shafts can very easily be made more fire resistive with self-furring metal lath or rib metal lath, plastered with a fire resistant plaster. Recent fire disasters have proved that an essential method of preventing the spread of fire, smoke and poisonous gases is the enclosing of vertical shafts and the installation of horizontal exits.

Vertical exits are absolutely essential for proper fire protection in any building, whereas horizontal exits are even more essential in a hospital. The tenth edition (1949) of the Building Exits Code published by the National Fire Protection Association presents new ideas, requirements and suggestions relative to horizontal exits. Too much emphasis cannot be placed on horizontal exits for hospitals and any renovation program should include this type exit as a requirement of its fire safety program.

Fire proofing old structures in a renovation program is essential. Wood stud walls with wood lath and plaster can very easily be converted into a minimum one-hour rated partition by an application of rib metal lath or self-furring metal lath and fire resistive plaster. Wooden floor structures can be made more fire resistive with many various coverings that will not only serve the purpose of increasing safety to patients but will also improve the appearance of the floor. Acoustical fiber board ceilings and other areas with combustible material can be given a coating of a fire retardent paint. Two of the recent disasters with a large loss of life might not have been so disastrous with the proper application of fire retardent paints.

A renovation program should include provisions for proper protection in the operating rooms. A new publication, "Safe Practice for Hospital Operating Rooms" by the National Fire Protection Association, should be essential reading for both the administrator and the architect on any renovation program.

Presentation Sisters Select Grafton and Park River for Hospital Sights

According to an announcement made recently by the Sisters of the Presentation of Mary at Fargo, construction of two new hospitals — one in Grafton and the second in Park River — will get under way as early as weather conditions will permit. Both hospitals will be operated by the Sisters.

The Grafton institution will be known as St. Joseph's Hospital. It will provide a minimum normal capacity of 40 beds, living quarters for the Sisters on the staff, a complete obstetrical and surgical department, X-ray and laboratory facilities, a chapel and complete kitchen, dining and laundry facilities. The cost, according to the announcement, has not been accurately estimated. $450,000 will be spent on the building and equipment.

St. Ansgar's Hospital is the name chosen for the Park River hospital. It will have a minimum normal capacity of 30 beds. Also included will be living quarters for the Sisters who will be on the staff, a complete obstetrical and surgical department, a laboratory, X-ray facilities and a chapel. It is expected to cost in excess of $350,000.

The construction of both institutions will be financed largely by the Sisters of the Presentation with the assistance of some local funds.

DON'T FORGET STAFF TRAINING

Regardless of the structural and mechanical improvements made for fire safety, one of the most essential elements to assure proper fire prevention and less loss of life during fires, is a well trained staff and a constant program of fire consciousness. Management is often too self-satisfied with what is believed to be a fire resistive building to take seriously the necessity of a planned disaster program on the assumption that "it won't happen here."

A renovation program with its primary concern of improvement of patient care should certainly consider the improvement of the comfort of the patient. Not only will the installation of additional toilet and lavatory facilities contribute to the comfort of the patient but these facilities will also reduce hospital personnel time, thereby effecting a double purpose of improving patient care while at the same time increasing efficiency of operation. Other comforts of the patient considered in renovation programs would be adequate heat, light, ventilation and air conditioning. Proper decorations of the renovated building add to the comfort of the patient.

The second major consideration in renovating a hospital is to consider the improvement of the operation of the hospital.

With new developments and new techniques, and with original ideas within each hospital, efficiency of operation of the hospital will by necessity require certain renovations. The present trend of hospital cost in addition to the fact that hospital personnel relations can usually stand improving, prompts the progressive administrator to seek every means for increasing the efficiency of the operation of the hospital. Caution must always be used to see that changes increasing the efficiency of operation do not adversely affect patient care.

It is definitely felt that unless a previously planned program was being carried out no annex or ad-

dition to a hospital can be made without renovations of the present structure. A planned addition to a hospital should embody a total overall planning of the entire structure, with such renovations as are necessary to improve the building for efficient and better patient care. Often hospital planners in their desire to build new construction, give insufficient attention to proper planning of the old structure, when a minimum amout of money spent in renovation would improve the total overall plant for efficiency far more than the additional new construction.

ADDED INCOME A POSSIBILITY

In any renovation program for the improvement of the operation of the hospital there are to be considered such items and elements as would contribute to an increase of income for the hospital. The addition of new departments, the addition of a new section or new equipment to present departments and the improvement of the patient areas will all have an effect on increased income to the hospital.

Another consideration in renovating the hospital from an operational standpoint is the creation of more pleasant areas and circumstances under which the hospital personnel work. This not only makes for more efficient and contented personnel, but cuts down turnover.

Any renovation program in a hospital should have as one of its primary objectives the improvement of the appearance of the hospital, both the exterior and the interior. The modernization trend of industry, hotels, department stores and others will certainly have its effect on hospitals. The public, which constantly sees modernization in the stores, is going to feel that the hospital is not abreast of current improvements if the same modernization ideas are not carried out in the hospital. Again this prompts the statement that "*now* is a good time to renovate."

The improvement of the appearance of hospitals certainly creates better public relations. A great public relations program can be built around a renovation program of the hospital with "before and after" photographs and with tours of the new departments as well as newspaper descriptions of the renovations and what they incorporate. This type of public relations is easily handled, not expensive and usually produces top results.

Other possible improvements in a renovation program are changes of utility distribution, installation of additional utility facilities and such items as "piped" music to various sections of the hospital, air conditioning of other sections of the hospital, and the general installation of items that would not normally be installed except in a renovation or original building program. Better lighting, improved nurses call systems (consider patient-to-nurse intercommunicating systems), office intercommunicating systems, staff paging systems, and many more improvements are needed in hospitals and are more economically installed during a renovation program. Another reason why "*now* is a good time to renovate."

As previously stated in this article, it appears that now is a good time to finance a renovation program. Governmental funds cannot do the entire program so consideration should be given to securing local funds. Hospitals are now enjoying good public relations, at a time when governmental funds are available, which means that "the iron should be struck while it is still hot" — it might cool off. Reasons to be used in a public fund raising campaign for a renovation program might be "Better Patient Care", "Better Fire Protection for Patients", "Better Medical Care", "Modernizing to Take Advantage of Late Developments", "Improving Hospital Service by the Addition of New Departments", "More Efficient Operation", "Improved Personnel Relations" and many more.

Though today is thought to be a good time for renovation there is no such thing as a blanket endorsement of all renovation ideas. The expense involved in modernizing an old building against the expense of replacing the building or a section of the building with a new structure may weigh the scales in favor of a new building.

No renovation program should ever be started without a plan for the current program and its relation to an ultimate overall renovation program. Temporary improvements are often indicated, however major renovation programs should be planned for long range installation and operation and consideration should always be given toward a possible expansion of the total facility.

Maternal Mortality Rates Drop Again in 1948

A continuation of the downward trend in maternal mortality shown by rates of 1947 is indicated by provisional figures for 1948 collected from state public health agencies by the American Medical Association.

"The United States undoubtedly will show a rate of not more than 1.2 maternal deaths per thousand live births in 1948, a drop of 0.1 from the previous year," says an editorial in a recent issue of the **Journal** of the American Medical Association.

"Twenty-seven states and the District of Columbia have rates for 1948 at least as low as one maternal death per thousand live births. The best state record was the phenomenal rate of 0.4 reported for Oregon. While this rate is provisional, Oregon made an outstanding record in 1948. Three states — Connecticut, Nebraska, and Utah — now hold second place, each with a rate of 0.6.

"Many other nations are also experiencing a considerable drop in their maternal mortality rates. The spread between the rates of the healthier countries continues to narrow. As maternal mortality rates approach the level of 1.0, they will no longer be a gage for comparison of the health of nations.

"Since 1933, the United States has made tremendous progress, with the rate declinning from 6.2 to 1.2 in 15 years; in 1947 the rates for whites and non-whites were 4.5 (5.6-1.1) and 6.4 (9.7-3.3) lower than in 1933. The spread between the highest and the lowest state rates decreased from 7.2 (11.5-4.3) in 1933 to 2.3 (2.7-0.4) in 1948. More important than the decline for the whole nation is the fact that the highest state rate in 1948 was 2.7, which was less than two thirds of the rate, 4.3 for the best state in 1933."

Today's hospital makes its own climate

Lewis A. Siberz, R.A., A.I.A.

CLIMATE AND MAN

Climate has throughout the ages been a direct influence on the habitat of both man and beast. Indeed architecture with all its complex developments had a simple origin in the primitive efforts of mankind to provide protection against inclement weather. Primeval man sought shelter in rock caves, under arbours of trees and in mud huts. The shepherd and the wandering nomad of the plains lived under tents made with skins of animals erected on poles.

It was only natural that prehistoric man should select the warm side of hills for his abode or stand with his face toward a pleasantly cooling breeze, or turn his back to a biting cold north wind. Animals, too, seek the warm slopes in winter and cool shade in summer.

We have, therefore, inherited a lesson from our historic forbears in the planning of our houses and buildings, seeking to take advantage of nature's gifts and to enjoy nature's giant heating system, the sun. Our modern buildings could well be planned to receive the sun in our northern countries and to shield us from its direct rays in tropical countries. Prevailing winds, too, are a great factor in bringing comfort to us in our modern abodes.

Modern man is affected mentally, emotionally and physically by climate and by changes in the weather. The weather affects our attitude toward other people, causes restlessness or satisfaction, affects the amount of work men do and greatly affects the attitude of the sick. Long periods of bad weather cause people to become irritated and depressed. So, too, changes in the weather stimulate the human being.

In North America we experience a wide range of weather conditions. In winter in the Dakotas we may have temperatures of 40° below zero, while in summer the desert regions of Utah and Arizona will register 130° above zero. Key West is like the tropics, while Montana is very cold in winter. All this while the human body maintains a constant temperature of about 98.6°.

There are many ways in which the hospital can make the most of its climatic surroundings as described by hospital architect Siberz.

The accompanying chart shows graphically a temperature portrait of weather conditions in nine cities representative of the entire United States. It is interesting to note that St. Paul which is almost at the northern edge of our country has every type of weather from very hot to very cold while Oakland, California, is almost entirely cool.

CLIMATE AND BUILDING DESIGN

For some extremes such as heat, cold and snowfall the United States equals any region in the inhabited world. Therefore, as typical buildings vary throughout the world from one climatic area to another, an appropriate hospital design for one part of our country will not necessarily be like that for any other part.

However, even though American climate is vastly different from North to South and from East to West there are problems which are common to all areas. Aside from general use planning these problems are insulation against excessive heat and cold, rain, wind and sun. It is obvious that these factors will differ from place to place in the amount of discomfort they cause, as well as their beneficial aspects. Solution to our problems, therefore, demands precise evaluation of these factors in their true local proportions, one to the other, and the intelligent application of scientific control measures.

The best design measures against cold may be in direct conflict with providing ventilation and relief from heat in summer. In a northern state we may require protection from the cold 75 per cent of the year, from the heat only 25 per cent whereas in a southern state the reverse is true. Therefore the northern architect would design primarily against cold with compromises against the heat, and conversely the southern architect would build primarily against heat with some allowances against cold.

Materials and methods of construction have become perfected which tend to neutralize the extremes of climate, such as roof insulation, wall insulation, double windows, weather stripping, air conditioning and automatic heating of buildings. All of these things are man-made, scientifically developed and used to maintain almost evenly perfect conditions within our buildings.

The modern innovations are proof against both heat and cold and therefore serve both the warm and cool parts of our country, only differing in the extent of application adequately to offset the elements. The architect's analytical judgment must determine what measures should be taken to meet local conditions.

We will discuss in more detail under the following headings the problems confronted in our endless battle against climate and the elements as well as a fuller enjoyment of life by taking advantage of the pleasant things climates have to offer.

CLIMATE AND SITE PLAN

The most desirable patient rooms of our hospital will generally face from Southeast to Southwest depending on our location. Our cooling breezes in summer come from the Southeast or Southwest while the cold of winter is on the North side. Any benefit from the sun would also be from the South in North America.

The accompanying illustration is an example of such a plan where the patient rooms are entirely on the desirable side of the building, while the secondary and utility rooms, elevators, etc., would be on the northerly side. It may have some disadvantages such as nursing travel and building cost, but for climatic exposure it is excellent.

This has not generally been done in planning hospitals. Usually the patient rooms are planned along both sides of a corridor with no regard for sun or breeze. If such a building had

one side toward the South and the other toward the North it would, of course, result in one side being sunny and the other not. Perhaps within the range of human beings we could find an equal number who would want sunny and shaded rooms. However, in a busy hospital it is not possible to reserve rooms for individual patient tastes. The writer believes, therefore, that a building with patient rooms on both sides of the corridor should be built with the corridor on a North-South line. By so doing one-half of the building will get morning sun and the other half afternoon sun. A refinement would be to tilt the plan a little toward the Northeast which would equalize the exposure to the sun by giving the East side a little more and the West side a little less of sun during the afternoon which is always warmer.

The accompanying illustration shows the sun which each room will receive under such an arrangement.

CLIMATE AND INSULATION

Our modern hospitals have adapted themselves to climate by using various methods of insulation. Northerly climates require insulation against cold and southerly climates against heat. Generally the same materials serve for both.

Various types and methods are employed in wall insulation such as cork linings for high or low temperature rooms, hollow masonry block lining for general rooms. Many localities use a wall construction 12 or 13 inches thick of which the outer four inches is brick and the inner eight inches of hollow masonry units. Such walls generally do not require additional insulation. If we assume a hospital room 12 feet wide and 10 feet high with a single window four feet by six feet the heat loss through the wall is about 40 per cent of the total room heat loss. Insulation is also packed around windows and other openings in exterior walls.

If the wall were lined (or furred) with metal furring, lath, and plaster, the heat loss would be reduced by eight per cent. If one-half inch insulation board were used it would result in a reduction of 16 per cent; if two inch cork were used a reduction of 25 per cent. It should be remembered that the initial heating system cost is reduced as well as operating costs throughout the life of the building by the use of insulation.

Roofs are and should be insulated in both hot and cold localities. Generally roof insulation is installed above the roof construction to prevent condensation on the under side of the roof slab. Such insulation can be an insulation board or insulating fill installed wet and allowed to harden similar to concrete, such as "zonalite." Roof insulation can be from one to four inches in thickness. Consider a 12 by 14 room just under the roof; without insulation the heat loss would be 7800 BTU while with two inch insulation the loss is reduced to 2370 BTU. Thus it becomes obvious that roof insulation is a worthwhile investment.

In buildings with pitched (or gable) typed roofs it might be better to use a loose rock wool fill in the ceilings of the upper rooms. However, if this is done the attic space would be well ventilated to prevent condensation.

There is a heat gain actually realized on the South side of buildings because of the sun, but no allowance is made for this gain in sizing the heating plant because we must be ready for a series of cloudy days as well as the night period.

In figuring cooling loads when buildings are equipped with air-cooled systems, a definite sun effect must be taken into consideration. Thus cooling figures are given for both the North and South exposures.

Consider a room 12 by 14 feet with a window four by six feet, single glass, the wall being four inch brick with eight inch back-up of hollow blocks, 95° outside and 80° inside. The total cooling load would be:

South Exposure	5350 BTU
North Exposure	2050 BTU

These figures would be improved if various wall insulations or double windows were to be used.

If the room were on a top floor the roof insulation shows a gain as follows:

Without insulation	3800 BTU
With two inch insulation	1690 BTU

We will show similar gains by using double glass windows under a following section of this paper.

We see, therefore, that insulating buildings has been a worth-while thing to do and should be carefully considered in planning a hospital both

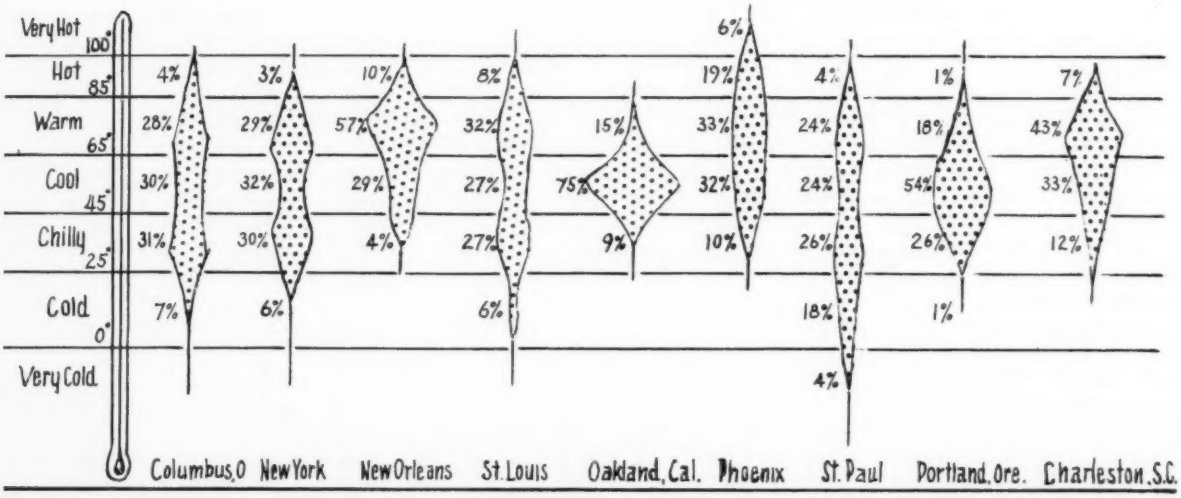
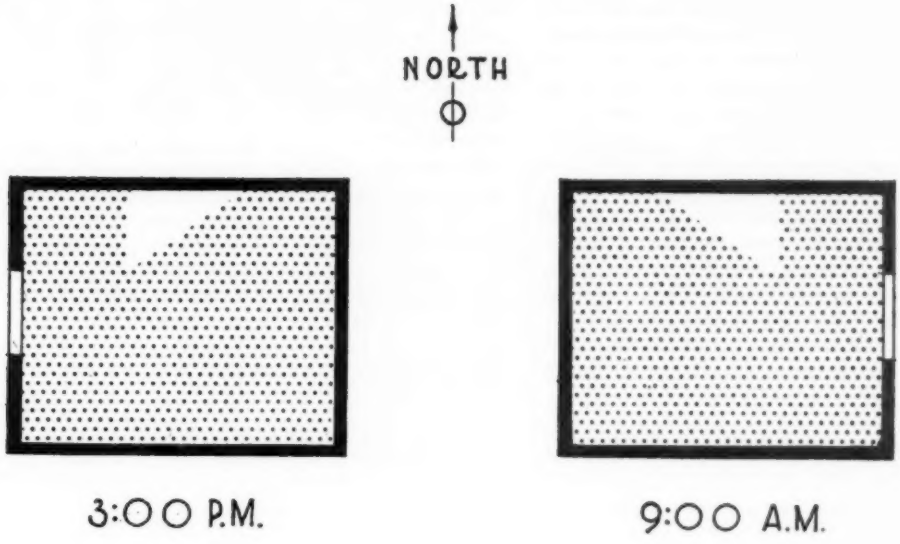


Chart indicates considerable temperature variation across the country.



Sunny room areas, a.m. and p.m.

for the comfort of those within as well as a reduction in original and operating costs of heating and cooling systems.

CLIMATE AND WINDOWS

There are many types of windows in use in our hospitals; some slide vertically, others project outward. We will concern ourselves more with size of windows, type of glass and the effect climate and sun may have on windowed openings.

The average hospital room of the past has had one window, perhaps about four feet wide and six feet high. This type of window is still used most commonly in hospital work. However, more and more glass has been used in all types of buildings in recent years and the trend has grown in hospital design. Larger windows and sometimes entire walls of glass do bring us in closer contact with the out of doors. Many hospitals for chronic diseases have one wall entirely of glass windows or doors, often leading to balconies.

Large window openings are indeed beautiful during nice weather, but can become a nuisance during extreme heat or cold. For instance, in computing the cooling load of an average 12 by 14 room we find as follows:

South exposure with 96 square feet of glass	15000 BTU
South exposure with 24 square feet of glass	5350 BTU

One can readily see that more glass creates a problem in heating or cooling systems.

We will not discuss the solar effect on the building because of larger windows since we cannot use solar gain in sizing heating plants on account of cloudy days and the night period.

Many buildings are now fitted with thermopane glass. Thermopane is one trade name for the relatively new product in glass consisting of two sheets of glass fused together along their edges in such way as to create a hermetically sealed air space between them, ranging from one-quarter to one-half inch. The size of these glass units ranges from one square foot up to as large as 64 square feet. Regular window glass, plate glass and obscure glass may be used. For extreme uses several sheets of glass and several air spaces are available.

Thermopane glass has reduced heating and cooling loads considerably as follows:

Heat loss in heating design	
For a window of 24 square feet of single glass	2400 BTU
For a window of 24 square feet of thermopane	1200 BTU

Likewise the cooling load on a southern exposure is reduced as follows:

For a window of 24 square feet of single glass	5350 BTU
For a window of 24 square feet of thermopane	3760 BTU

Thermopane glass is not prohibitive in cost and should quickly pay for itself in savings of heat.

Weather stripping is used quite universally in our colder climates. It prevents the leakage or infiltration of cold air between the windows and its frame. Such leakage can amount to one-third of the total heat loss from a hospital room with one window. Of course if more windows are used the lineal feet of leakage increases greatly.

A great deal could be written about various windows used in hospitals. Metal windows are used of steel and more recently of aluminum. Steel windows have not always closed tightly and some parts have rusted. Aluminum seems to pit and darken in industrial areas, however they do close more tightly.

Wooden windows have given good service and can generally be repaired or refitted by the house carpenter. Reversible wooden windows are easily washed from inside and have been used extensively in hospitals.

CLIMATE AND BALCONIES

The use of porches in connection with general hospitals and also hospitals for the chronically ill has generally been given up, partly because every bit of floor space has been utilized for bed space and also because they have been superseded in chronic hospitals by the open balcony.

The early sanatorium laid great

stress on fresh air. Rooms and wards were therefore planned with adjacent porches in front of them where the patient took his cure by sitting in the sun or sleeping in cold fresh air at night. The rooms behind these porches were generally dark and gloomy. Gradually these porches have been superseded by the open and shallower balcony which is so planned as to allow the patient to enjoy the out of doors on a nice day and yet have a sunny and pleasant room most of the while. Large windows make such rooms very attractive. Usually balconies are shaded from the direct rays of the sun by the balcony of the floor above or by "sun visors" above or built vertically at intervals to afford shady corners when desired.

An example of balconies at each floor designed in such manner as to shade the patients room is the Goldwater Memorial Hospital in New York. Here the balcony was made five feet wide.

Experiments have proved that bacteria growth would diminish in rooms with larger areas of glass windows, or in warm climates entire walls could be opened to the outdoors. It is also obvious that the daylight and sunshine is of great value in cutting down cross-infection in communicable disease wards. In planning bed arrangements in rooms where most of the exterior wall is glass the architect must never face the patient toward the glass so that he must always look toward the window glare.

There are many things not yet known about glass and its function in passing daylight to the room. Is its thickness a factor? Are several sheets a factor? We have several types of heat resistant glass, but do they remove some of the beneficial qualities of the sunshine? These are things the architect must be informed upon to guide him in his future hospital design. We are sure however that more daylight is a good thing especially in order to obtain the greatest therapeutic result for the patient.

Some people believe that with air conditioning windows are not necessary. Various peculiar things have happened where rooms are entirely without windows; people have fainted, work fatigue is more evident and general discomfort has resulted. Experiments have placed men in completely air conditioned cells without windows and their blood pressure and other physical reactions have indicated discomfort. We believe that people like to see the outdoors even though room comfort is perfect.

Another type of balcony is the receding balcony where each story is set back from the story below. This construction allows a maximum amount of sunlight to enter the rooms all day if desired. This type of hospital has been built in several instances in Europe. It would be ideally suited to a hill side, but in any case could not be a very high building. Usually, here too, a sun visor is used partially to shield the patient from the sun.

In our largest hospitals the use of receding stories in the upper parts of the buildings have afforded sun decks which are pleasant in nice weather.

CLIMATE AND THE FUTURE

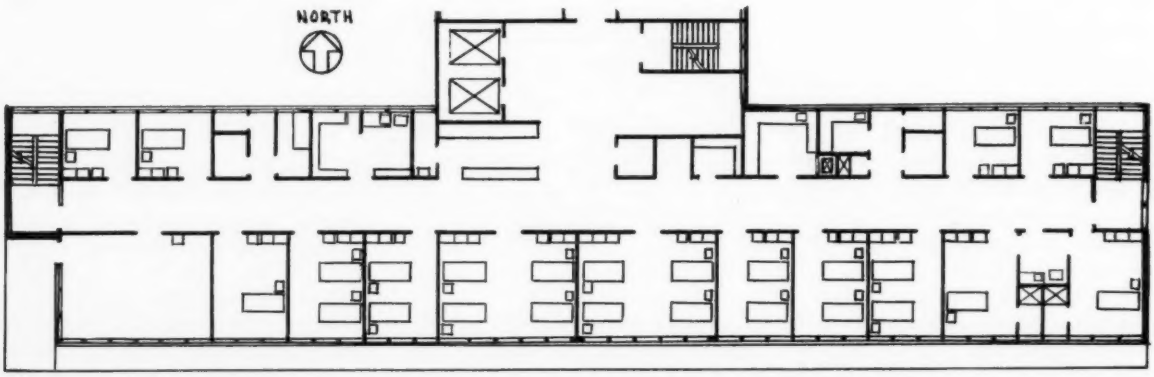
What will the future bring to the design of hospitals and their relation to climate? How will we better use her choicest gifts and yet at the same time shield us from her inclement days? Certainly we will find new ways to making better materials which will allow beneficial qualities of the sun to reach our bodies and which will also further cut down heat losses from buildings.

This means larger windows and perhaps entire buildings of glass. Man may again return to life in the open and at the same time be shielded from the elements.

Air conditioning will give us perfect comfort indoors while we can look out through glass without glare. Air conditioning, too, may have germ killing powers so that entire buildings may be kept sterile. People upon entering such buildings will become relieved of certain afflictions after a short while within the building. Such buildings are already a partial reality. It is not impossible to imagine buildings of the future which will rotate on a huge central axis so as to better utilize the benefits of climate.

Our good judgment should always prevail in accepting new ideas. Some have not proved to be good. The end result is the effect on the patient. He is and always will be the primary concern of the hospital. If he gets well and feels better while in the hospital because of large windows and more daylight, then we should design toward that end and devise new methods of controlling the sun and preventing loss of heat in cold weather.

People seek certain pleasant aspects of climate while they are living normally; does it not seem logical that the same pleasantness should be brought to them when they are sick?



Hospital nursing ward showing patients' rooms arranged above the south wall toward the sun.

Conducted by Margaret Foley, R. N., M. S.

Anent the regional institutes

It seems appropriate to begin the New Year's column with a tribute to the schools of nursing which will mark in 1950 half a century of educating students in nursing, and to the Sisterhoods which conduct these schools. In recognition of the splendid contribution of their thousands of graduates to the nursing profession, and to the Christian ideal of nursing we say "Congratulations."

Sisters of Providence — Holyoke, Mass.
- Providence School of Nursing, Holyoke, Mass.
- Mercy School of Nursing, Springfield, Mass.
- St. Vincent's School of Nursing, Worcester, Mass.

Sisters of Mercy of the Union
- St. Joseph's School of Nursing, Atlanta, Ga.
- St. Joseph's Mercy School of Nursing, Clinton, Ia.

Daughters of Charity of St. Vincent de Paul
- St. Vincent's School of Nursing, Birmingham, Ala.
- St. Paul's School of Nursing, Dallas, Tex.

Sisters of Mercy — Burlingame, Calif.
- St. Mary's School of Nursing, San Francisco, Calif.

Sisters of Mercy — Albany, N. Y.
- St. Peter's School of Nursing, Albany, N. Y.

Sisters of Our Lady of Mercy — Charleston, S. C.
- St. Francis Xavier School of Nursing, Charleston, S. C.

Poor Sisters of St. Francis
- St. Elizabeth's School of Nursing, Lafayette, Ind.

Sisters of the Third Order of St. Francis — Glen Riddle, Pa.
- St. Joseph's School of Nursing, Tacoma, Wash.

Sisters of Charity of Cincinnati
- St. Joseph's School of Nursing, Mt. Clemens, Mich.

Sisters of Charity of St. Elizabeth — Convent Station, N. J.
- St. Mary's School of Nursing, Passaic, N. J.

Sisters of St. Joseph — Brooklyn, N. Y.
- St. John's School of Nursing, Long Island City, N. Y.

Sisters of St. Joseph — Wheeling, W. Va.
- Wheeling School of Nursing, Wheeling, W. Va.

The Institutes

During the nine weeks from October 9 to December 6, approximately 1000 Sisters and lay faculty members of Catholic schools of nursing, hospital administrators, and religious superiors attended one of seven Regional Institutes on Nursing Education sponsored by the Conference of Catholic Schools of Nursing in Boston, Philadelphia, Chicago, Seattle, Kansas City, New Orleans, and Cincinnati. Planned for the primary purpose of assisting the schools of nursing in their efforts to carry out to the fullest the Catholic philosophy of nursing education, the intensive program marked the first attempt to offer regional services to members of the Conference.

The advantages of regional programs are evident from the attendance records of the Institutes. Three hundred Catholic schools of nursing (collegiate, hospital and practical) sent representatives to these meetings, as well as several hospitals offering affiliation in the specialty areas. Individual Sisterhoods participating totaled ninety-five — or 90.5 per cent of all Sisterhoods engaged in nursing education in the United States. Only thirteen schools of nursing are conducted by the Sisterhoods which did not find it possible to attend one of the Institutes. All Catholic schools participated in each of 15 states and the District of Columbia. There was representation from forty-four states and four provinces of Canada.

Much of the credit for the success of the Institutes is due to the cooperation and enthusiastic support of the local committees. The names of committee members in each area are listed in the October, 1949, issue of HOSPITAL PROGRESS. Also, it would have been impossible to conduct these programs without the effective contributions of the thirty-five faculty members who are listed elsewhere in these pages.

There are no momentous decisions to be reported as resulting from the Institutes. It is not even possible to judge whether or not one of the immediate purposes of the activity was accomplished — i.e., assistance in preparation for national accreditation — since the progress toward accreditation will be gradual. If the spontaneous enthusiasm of the audiences and the interested participation in discussion may be taken as evidence, it would seem that the Institutes met a felt need in our schools. It remains for time to tell how effective they have been in helping them to solve their immediate problems.

OPINION POLLS

With such a wide representation of Catholic nurse educators available, the Institute offered an excellent opportunity to record the attitudes, opinions and fears prevalent in the schools. The opinionaires used for this purpose, are summarized here as representative of current thinking on the part of nurse educators in the Catholic field.

QUESTION: Do you believe the policies and criteria in the N.A.A.S. Manual are fair to three year schools?

ANSWER: Yes, 56%. No, 17%. Don't Know, 27%.

Slightly over half of the questionnaires (56 per cent) indicated that the policies and criteria of the Manual are fair — a rather high percentage (27 per cent) stated frankly that the individuals had not read the Manual. This figure might be discounted on the ground that many of those present could hardly be expected to be familiar with the Man-

ual. However, of the directors present, about the same percentage did not feel that they could answer the question. Those with definite objections to the accrediting criteria totaled 17 per cent. Most of these explained that they felt the criteria would prove difficult for three year schools to achieve, particularly small schools.

Regionally there was a significant difference in opinion on this question. Both the Seattle and Cincinnati Institutes registered 71 per cent approval of the criteria. Rank order for the attitude expressed in the other cities is as follows: Chicago — 61 per cent; Kansas City — 49 per cent; Boston — 46 per cent; and Philadelphia — 40 per cent. The largest percentages expressing positive dissatisfaction were recorded in Philadelphia and Kansas City — both with 29 per cent. Boston revealed the largest number of those who preferred to offer no definite opinion — 42 per cent.

QUESTION: Are you fearful of the accrediting movement?

ANSWER: Yes, 24%. No, 69%. Don't Know, 7%.

The majority of our Institute participants were not disturbed by the accrediting movement, although they acknowledged the necessity for sincere effort toward accreditation. Many welcome it as a required stimulus to improvement.

Those who expressed fear of the accrediting movement generally explained that this opinion was held in terms of a local situation. They represented small schools; or rural schools; or had been facing a particular obstacle for which there seemed to be no immediate solution. It would seem that approximately half of those who could not offer an informed opinion in regard to the Manual itself were nevertheless sufficiently aware of the implications of accreditation to respond to this question.

The South appeared to be most serene in the face of accreditation with 87 per cent expressing no fear. Cincinnati followed closely with 86 per cent. The remaining five areas revealed the following favorable reactions: Seattle — 79 per cent; Philadelphia — 74 per cent; Boston — 63 per cent; Kansas City — 60 per cent; and Chicago — 58 per cent.

QUESTION: Do you fear the Administrative Separation of Nursing Education and Nursing Service?

ANSWER: Yes, 19%. No, 76%. Don't Know 5%.

The proposal to separate the administrative functions of nursing education and nursing service not infrequently raises the objection that the student is thereby being removed from the patient and that the "spirit of nursing" is being violated. Opinions were sought on this question to stimulate comments and to determine how widespread is the distrust of this separation. The response in favor of this *administrative* separation was surprising — 76 per cent — although those who advocated it emphasized the need for close cooperation between educational and service personnel. In several cases the 19 per cent expressing fear of the movement included those who feel it would not work in a small institution. Some few comments indicated that the participant interpreted administrative separation as an undesirable step in the direction of education divorced from the bedside, but these were a small minority.

Boston and New Orleans with 10 per cent each of affirmative replies to this question registered the least concern, while Seattle, with 30 per cent affirmative replies expressed the most definite disapproval. Only slight variations occurred in the other four cities where the affirmative votes ranged from 18 to 20 per cent.

QUESTION: Do you favor the education of practical nurses?

ANSWER: Yes, 84%. No, 16%.

Having received previous indication that sub-professional personnel are contributing to nursing service, with rare exception, a highly favorable response to this question would be expected. Regionally, opinions varied slightly, although in no case was there less than the 74 per cent for practical nurse education recorded in Chicago. Characteristically, the South with its relatively low supply of nurses as revealed in the recent Inventory of Professional Registered Nurses offered no definite opposition to practical nurse education.

QUESTION: Do you favor the use of the Interim Classification of Basic Schools of Nursing to determine eligibility for Federal Aid?

ANSWER: Yes, 39%. No, 44%. Don't Know, 17%.

Although the Conference has no defined policy towards the Interim Classification of Basic Schools of Nursing, it was inevitable that this topic would come up for much discussion. Due to the unfortunate confusion between the purposes of the National Nursing Accrediting Service and those of the Interim Classification, it was considered advisable to include on the program an objective explanation of the Interim list. It was possible, through group discussion, to clear up many misconceptions regarding Interim Classification and to point out that it is an activity which should be considered completely apart from the accrediting movement. The impression received from the discussions was that the participants found much to be desired in the Interim list; that they regretted the haste with which it was necessary to compile the list; and that, in some instances, it was difficult to understand the rating given to a specific school, particularly in cases where a school was given higher ranking than popular opinion considered warranted.

In view of these verbally expressed opinions, the total of 39 per cent in favor of the use of Interim Classification to designate schools eligible for Federal aid may be considered significant. From the comments accompanying the opinions, it was clear that the attitude on this question was influenced primarily by the position of the individual school on the list, and secondarily by the position of other schools conducted by the Sisterhood. On this question, probably the opinions of directors themselves should be given particular consideration. In this group 43 per cent favored the use of the Interim Classification in Federal Aid; 47 per cent did not favor such use; and 10 per cent offered no opinion. It should be noted, however, that even among those who would approve the use of the Interim Classification, should Federal aid become available, there was not unanimity of opinion as to the desirability of Federal aid itself.

QUESTION: What do you consider the most serious prob-

lem confronting nursing education today?

The replies to this question were perhaps the most significant key of all to the attitude of the participants. In view of the changing character of nursing education and the wide dissatisfaction with some proposals which have been made, the answers here might have followed the "I'm against it" theme. On the contrary, however, the problem most frequently mentioned was that of faculty shortage. It seems indicative of the positive approach of our schools that this problem was recognized by all — hospital administrators, directors, instructors, and clinical specialists. All phases of the matter were mentioned: How can we secure adequately prepared faculty? What can be done to attract faculty members to rural areas? How can we stimulate graduate nurses to prepare themselves for faculty positions? What can be done to ensure the most effective faculty functioning?

The second problem in order of frequency had to do with emerging patterns of nursing education. In this category the following problems were mentioned, each with a frequency of twenty or less:

Too much emphasis on the collegiate program.

Confusion and general bewilderment due to too rapid change.

The uncertain future of the three year school.

The necessity of revision of the three year curriculum—i.e. what is this nurse to do, and how long should her preparation be?

Fear that bedside nursing will be turned over to the practical nurse—and the indefinite future of the R.N.

Accreditation.

Provision for more adequate nursing service in rural areas.

Financing the educational program.

A third group of comments may be considered under the classification of philosophy of nursing education. In this category the following comments occurred:

Too much emphasis on theory of nursing and too little on clinical experience.

A loss of the "spirit of nursing"; forgetting the patient; secularism; and materialistic philosophy of nursing. (Unfortunately, there are no examples of these "isms" — and no assurance that a single definition of "spirit of nursing" is universally accepted. In total, these comments were less than 50).

The need for a better understanding on the part of all concerned of the aims, objectives, and requirements of nursing education and better cooperation between education and service personnel.

EVALUATION OF THE INSTITUTE

If we are to believe even the proverbial half of the comments written by the participants, we may conclude that these meetings were found to be worthwhile, practical, and helpful. Perhaps the overwhelmingly favorable response was explained in part by the director attending the New Orleans Institute who wrote: "The underlying motive to render aid to us gave a feeling of unity and security not felt at other institutes conducted under other auspices." A similar reaction is expressed by a lay instructor who participated in the Cincinnati meeting. She writes as follows: "I was singularly impressed with the feeling of unity which pervaded the Institute. I believe this arises from the Catholic viewpoint which the Institute fostered. I do not think this attitude was one of imitation or 'follow-the-leader' but of unity of purpose based on Catholic philosophy."

Perhaps the most frequent suggestion received was that a program of regional institutes be sponsored annually. The reasons advanced for this suggestion were that a better opportunity is afforded for discussion of problems peculiar to the region; more active group participation is possible in these smaller meetings; and a larger number from each school can attend.

Of course, all were not completely satisfied with the program as presented. While the majority found time allotment and meeting arrangement satisfactory, a few suggested shorter institutes. One frequently recurring comment asked that Mothers General and Mothers Provincial of religious orders be given special invitations to attend future institutes and expressed regret that they had not been present in larger numbers.

Undoubtedly the most popular features of the Institute were the emphasis on the obligations and responsibility of Catholic schools of nursing and the exposition of the way in which these schools can achieve the dual purpose of offering sound professional education and at the same time effectively implementing the Catholic philosophy of nursing education. Although the policy of the Conference of Catholic Schools of Nursing relating to accreditation; and the three year school; collegiate programs; and practical nurse education has been published several times in the past two years, this was an opportunity to re-iterate the platform and to examine local problems in the light of the policy of the Conference.

For those who participated in all seven Institutes, there was an unusual opportunity to secure an over-view of Catholic schools of nursing. In general, this view is most heartening. Our schools appear to be no better, certainly no worse, than any other schools in the country. It seems evident that by maintaining their present sane and realistic approach to their task, and their traditional devotion to the Christian ideals of nursing, Catholic schools of nursing can emerge from the present confusion in nursing education the better for the experience.

In response to requests from the Institute participants, a proceedings summarizing the faculty contributions of the seven programs will be made available. No date of publication for these proceedings has been determined.

Nursing News

Mercy, Des Moines, Celebrates 50th Year

Mercy Hospital School of Nursing, Des Moines, Iowa, marked its 50th year with a two-day celebration on November 19 and 20. Established in 1899, the school has graduated a total of 880 students.

The jubilee observance was sponsored by the Sisters of Mercy and the alumnae of the school. Included in the program was open house at the nurses' home and a home coming banquet which honored two members of the first graduation class, Mrs. Emma Tyrell and Miss Christine Hoffman, both of Des Moines.

* * *

Recently our "clipping service" turned up a news item which referred to "St. Joseph's Nursing and Advisory Foundation, Inc., Marshfield, Wisconsin." A letter to Sister M. Edith, Director of St. Joseph's School of Nursing, Marshfield, asking for further details concerning this example of excellent public relations brought the following response:

"Due to the shortage of students in St. Joseph's School of Nursing, Marsh-

field, Wisconsin, in 1947 a few generous citizens including some of the hospital's medical staff members, formed the St. Joseph's Nursing and Advisory Foundation. They elected officers, formed a board of directors and set their purpose and goal.

"The tuition of the school at that time was $198.00 for the three year course. The Foundation offered to raise money by drawing a large membership and thus have a special drive to gain financial support. They advertized in all papers and magazines possible as to the financial help offered to prospective students. The Foundation offered to pay 1/3 of the tuition, the hospital paid 1/3 and the student paid the other 1/3. Thus the students pay for the three years only $66.00.

"The foundation is still active by raising funds for scholarships and recreational purposes. They offered two scholarships in 1947, four scholarships in 1948 and four in 1949.

"The students admitted in 1949 pay their own tuition which was raised to $240.00. This change of policy this year has not affected the number of students admitted in any way.

"We feel that this Foundation has been particularly helpful in our recruitment program. Their help is appreciated especially since they now offer the many scholarships to worthy students. We feel free at any time to call on them when in need of a bus or cars to take students on trips, such as the basketball team when playing with students of other schools outside of the city.

"They have sponsored formal dances for which they provided the orchestra for our students. Members of the recreational committee have helped to obtain speakers for the students once a month. They sponsor one tea each month for students in the homes of individual members, and all students have an opportunity to attend one."

* * *

1949 Nursing School Admissions Total 43,612

Schools of nursing throughout the United States admitted a total of 43,612 first-year students in 1949, the largest class in any peacetime year, it has been announced by Dr. Theresa I. Lynch, chairman of the national Committee on Careers in Nursing and director of the Department of Nursing Education at the University of Pennsylvania. This year's admissions to the approximately 1200 state-approved schools in the country represents an increase of about one per cent over 1948 which also set a record for a peacetime year when 43,373 students entered. The survey also reveals that a greater number of students entered fall classes in 1949, approximately 1100 more than in 1948, although the first six months' admissions decreased by 850 compared with 1948, according to Dr. Lynch.

Increases in student admissions were reported in 26 states, ranging from one per cent to 52 per cent. All the Middle Atlantic and Pacific states and all but one of the New England states showed more students admitted. A total of 21 states revealed decreases, ranging from one to 22 per cent.

States enrolling more than 1000 students include: California, Illinois, Indi-

(Continued on page 36A)

C.C.S.N. REGIONAL INSTITUTES
The Faculty

FINANCE	Address	Institute
Dr. Louis Block	Washington, D. C.	Boston, Philadelphia
Sister M. Gerald, C.S.C.	Holy Cross, Ind.	Chicago
Miss Virginia Olcott	Seattle, Wash.	Seattle
Mr. M. R. Kneifl	St. Louis, Mo.	Kansas City, New Orleans, Cincinnati
SCHOOL-FACULTY ORGANIZATION		
Sister Agnes Miriam, S.C.N.	Washington, D. C.	Boston
Sister M. Olivia, O.S.B.	Washington, D. C.	Philadelphia
Sister Ancina, O.S.F.	Winona, Minn.	Chicago
Sister M. Digna, C.S.A.	Fond du Lac, Wis.	Kansas City, New Orleans
Sister M. Edith, C.S.A.	Cleveland, Ohio	Cincinnati
Miss Ann Weisenhorn	Colorado Springs, Colo.	Seattle
ACADEMIC ADMINISTRATION		
Sister Madeline Clemence	Lowell, Mass.	Boston
Sister Herman Joseph, O.S.F.	Wilmington, Del.	Philadelphia
Sister Agnita Claire, S.S.M.	St. Louis, Mo.	Kansas City
Sister Henrietta, D.C.	New Orleans, La.	New Orleans
Sister Maurice, R.S.M.	Detroit, Mich.	Cincinnati
Sister Bernarda, O.S.B.	Duluth, Minn.	Chicago
CLINICAL TEACHING		
Sister Josephine, D.C.	Boston, Mass.	Boston
Sister Bernadette, D.C.	Washington, D. C.	Philadelphia
Sister Aniceta, O.S.F.	Pittsburgh, Pa.	Chicago, Cincinnati
Sister Berno, O.S.B.	St. Cloud, Minn.	Seattle
Sister Digna, C.S.A.	Fond du Lac, Wis.	Kansas City, New Orleans
GUIDANCE AND DISCIPLINE		
Rev. James F. Moynihan, S.J.	Boston, Mass.	Boston
Rev. Francis P. Lively	Brooklyn, N. Y.	Philadelphia
Rev. Louis B. Snider, S.J.	Chicago, Ill.	Chicago
Rev. Clement H. Regimbal, S.J.	Spokane, Wash.	Seattle
Rev. Edward J. Weisenberg, S.J.	St. Mary's, Kans.	Kansas City
Rev. E. J. Rojero, S.J.	New Orleans, La.	New Orleans
Msgr. Robert A. Maher	Toledo, Ohio	Cincinnati
STUDENT ADMINISTRATION		
Miss Rita Kelleher	Boston, Mass.	Boston
Miss Rita Grogan	Omaha, Neb.	Kansas City
CENTRALIZATION		
Miss Ann Weisenhorn	Colorado Springs, Colo.	Seattle
Misses Nathe, Hankins; Mesdames Sullivan, Adrion; Sister Mary David	Grand Rapids, Mich.	Chicago
INTERIM CLASSIFICATION		
Miss Ruth Sleeper	Boston, Mass.	Boston
Sister M. Geraldine, S.S.M.	St. Louis, Mo.	Kansas City

GENERAL

Rev. John J. Flanagan, S.J. Margaret Foley

HEALTH LEGISLATION

George E. Reed

A.M.A. vs. Administration

With the second session of the 81st Congress less than a month away, the parties to the controversy involving a national health insurance program are feverishly marshalling their forces. The American Medical Association has just adopted a recommendation by its Board of Trustees which establishes, for the first time, annual dues up to $25.00 a year, which will be used to build a war chest. These dues are mandatory, payment being a condition to continued membership in the American Medical Ascociation. Secondly, a special five-man committee has been established for the purpose of investigating medical care plans abroad. This committee will make an extensive study of the various health plans in effect in Europe. One of the reasons why the American Medical Association has decided to assess dues against all of the members is the exorbitant cost of its attempt to prevent the enactment of a compulsory health program. For instance, the Association will soon initiate a propaganda campaign in which the Administration's health program will be subjected to attack in practically every newspaper in the country. This drive will reportedly consist of full page ads denouncing the President's program as "socialized medicine."

Meanwhile, the House Lobby Investigating Committee has announced that it will demand a report from major insurance companies on funds which allegedly are being spent in the American Medical Association's battle against the President's health insurance program. The committee will demand the accounting on the ground that the insurance companies may be violating the law in using policy-holder money for this purpose.

The American Medical Association apparently intends to extend its attack not only to the Administration's Health Bill but also to the provisions of the pending Social Security Bill which provides for disability benefits. The American Medical Association has taken this stand on the basis of the proposition that such legislation will constitute an "entering wedge" for a national health insurance program.

The opponents of compulsory health insurance were recently encouraged by the following statement of Senator Hubert Humphrey of Minnesota. "It is my considered judgment that legislation for health insurance is not yet in the legislative action stage and will not be in that stage, regardless of its merits, until there have been further hearings, further research, and until a primary basic Administration formula has been developed." Senator Humphrey likewise observed that the administrative problems involved in a national health program predicated on compulsory health insurance are so formidable as to require extended study.

Washington commentators do not look upon the statement of Senator Humphrey as indicating a major defection in the Administration health insurance ranks. On the contrary, it is felt that Senator Humphrey was merely echoing the basic strategy of the Administration — a strategy which looks forward to the enactment of the complete Administration program in 1951; the intermediate time being used to secure the adoption of the less controversial points in the President's program, such as special health assistance to rural areas, assistance to states for maternal child health and crippled children services. In short, it is felt that the Administration desires to use the threat of a national health plan to secure the adoption of all of the announced health goals with the exception of compulsory insurance. It is felt that this can be made a key issue in 1950 and that the people of the country will give the Administration a vote of confidence which will be sufficient to insure passage of this controversial measure.

Another key Administration man, Senator Paul Douglas of Illinois, has announced his support of a health program which is much more limited in scope than that which is being advocated by the President. Senator Douglas stated that his plan "would be confined to catastrophic illnesses — those which really crush a family financially and which lay up the money maker for a long while." Senator Douglas indicated that the cost of the Administration plan would run around $5,300,000,000 a year, whereas his health program would require around $1,760,000,000 annually. The plan would be financed by a payroll assessment. Senator Douglas observed that his plan is based "on the real principle of insurance — protection against great loss." The plan of Senator Douglas will no doubt be given extensive support. However, it embodies the principle of compulsory health insurance and will, in all probability, be opposed by the American Medical Association.

Shortly before the American Medical Association Convention in Washington, The Physicians Forum held a convention in New York. This convention went on record as favoring the adoption as soon as possible of a comprehensive national health insurance program. At the meeting, Dr. Louis Hollander, President of the New York State CIO Council,

$1,000,000 Hospital to be Erected in Mankato

The Sisters of the Sorrowful Mother of the Third Order of St. Francis have announced plans for a new $1,000,000 hospital to be erected on a five acre tract in Mankato. The new hospital will have 200 beds, and the six story structure will replace the present 142-bed hospital.

and Vice-president of the Amalgamated Clothing Workers, announced that his own union was establishing health centers as a stop-gap until a Federal plan is enacted and that "literally hundreds of doctors have offered to serve us."

Of equal interest to the preliminary skirmishes involving a compulsory health program was the publication of a 15-month hospital study which has just been completed for the State of New York by a committee under the chairmanship of Dr. Eli Ginzberg. This report of 368 pages, which was written by Dr. Ginzberg, an associate professor of economics in the graduate school, Columbia University, embraces a detailed study of the major aspects of hospital care in the State of New York.

The Ginzberg report concluded that the voluntary hospitals of New York are getting into a "tolerably decent economic position" and therefore, do not need subsidies from the state. The report indicates that if business conditions remain stable, the voluntary hospitals should make an even better financial showing. The reason for this optimism is the rapid expansion of the Blue Cross insurance plan. The report indicates that 57 per cent of the entire population of New York State now has some form of prepaid hospital insurance: 5,200,000 persons are currently enrolled in the Blue Cross plan and an estimated 3,200,000 persons have commercial insurance or are enrolled in special industrial groups. It was estimated that 85 per cent of the people in New York are capable of paying a premium which would insure them against the risks of acute hospitalization. Dr. Ginzberg said that this would be particularly true if employers would help in paying the premiums for low income workers.

The report strongly recommended that the Blue Cross and other hospital plans provide diagnostic and ambulatory services. It was indicated that the greatest difficulty of the individual citizen is not the problem of getting into a hospital, but rather "getting adequate diagnostic services at the price he can pay." In order to help alleviate this condition, the report recommends that voluntary hospitals be reimbursed out of public funds for welfare clients using diagnostic and ambulatory services.

One of the most far-reaching recommendations is that which would controvert the New York State Joint Hospital Survey and Planning Commission to a State Hospital Commission with the power to exercise broad supervision over all hospitals, including voluntary ones. In connection with this recommendation, the report recommended that voluntary hospitals recognize their responsibility to make their facilities as available as possible to all competent doctors in the State. It was asked that the State establish a hearing system "for aggrieved physicians." It is felt that this report will be given wide circulation and will have a pronounced effect on the whole health picture with respect to the voluntary hospital. At a later date a more complete analysis of this report will be given.

Another interesting development in the field of health and hospitals is the formulation of the Inter-association Committee on Health, which was established a few weeks ago. This Committee consists of the American Dental Association, American Hospital Association, American Medical Association, American Nurses' Association, the American Public Health Association and the American Public Welfare Association. Dr. Philip E. Adams of Boston, who was the chairman of the meeting at which the Committee was formed stated that "it is to be hoped that this group, representing large associations of national character, can present a united front on many of the problems that affect health and welfare of the American people." There is no indication that the committee intends to participate in the controversy on compulsory health insurance. The committee did, however, strongly endorse the current survey of medical schools by the American Medical Association, The Association of Medical Colleges, and the United States Public Health Service. The committee indicated that the results of those surveys should be awaited before determining specific needs of medical schools and urged a proper survey of other educational institutions in the field of health with the same power and with the use of Federal funds.

It is too early to assess the probable results of the developments just reviewed. However, they indicate at least an acknowledgment of the health needs of the Nation and the necessity for a concerted attack upon those factors which militate against the maximum extension of health services to every individual. The only question now is the method, not the goal.

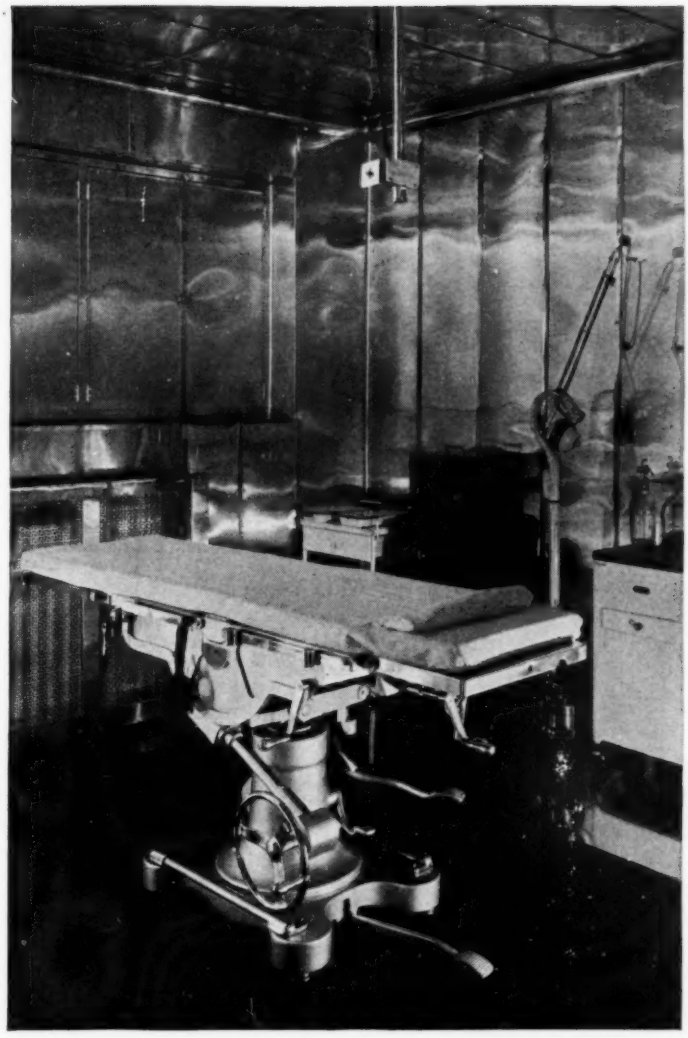
COLD-SUSCEPTIBLE PERSONS RATE HIGH IN ALLERGIES

Weather changes and wet feet often get the blame for frequent colds, but two University of Illinois doctors are convinced that a hidden allergy may be at fault. People for whom life is just one sniffle or sore throat after another during the common cold seasons have more allergies than hardy persons who resist the virus, Drs. Noah Fox and George Livingston of Chicago found.

Reporting in a current issue of Archives of Otolaryngology, published by the American Medical Association, the doctors describe a study of more than 3,000 cold victims of all ages and walks of life. Only 358 of this cold-susceptible group had no personal or family history of allergy, while 2,127 were or had been allergic.

"Frequently allergy goes unnoticed because it is of the borderline variety," the doctors write. "The nose and pharynx [throat] of the cold-susceptible patient must be examined to ascertain whether there are changes in the structures. The mucous membranes of the allergic person seem always to harbor organisms, ready, when the proper stimulus occurs, to overgrow.

"Although it is popularly believed that exposure to cold, humidity, fatigue, and debility are associated with lowered resistance to the common cold, confirmatory laboratory data are still lacking. However, these same factors are known to influence severely the allergic state of a patient. "The great frequency of other allergies in the cold-susceptible person or in members of his family suggests a specific allergy to the virus or its proteins."



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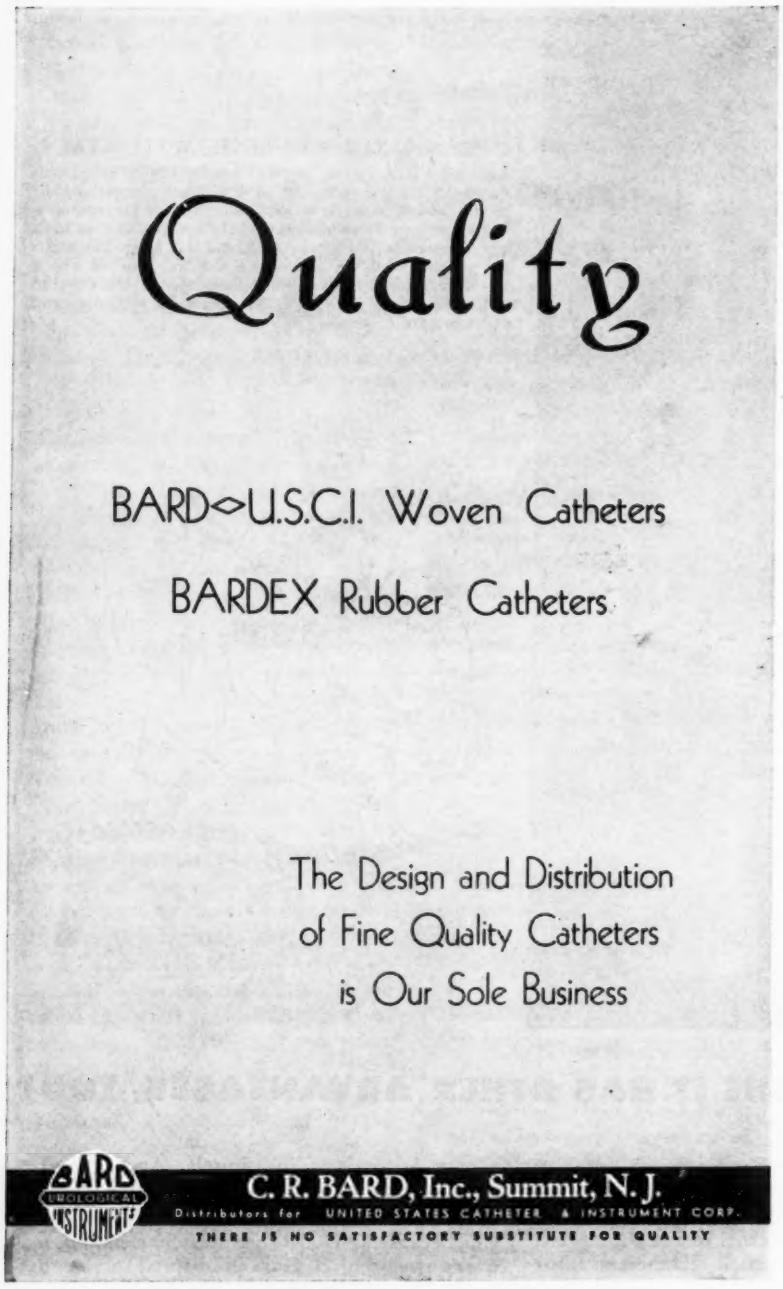
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HOSPITAL ACTIVITIES

General News

CANADA

Hotel Dieu Nuns Set Up Generalate in Kingston

A number of Canadian and United States monasteries of the Hotel Dieu Sisters recently united under one generalate with their motherhouse in Kingston.

Mother Cecilia Murray of St. Bernard's, Chicago, Ill., is the first Mother General of the new congregation which is to be known as the Religious Hospitallers of St. Joseph. The congregation was erected by a decree issued by the Sacred Congregation of the Affairs of Religious. The setting up of the generalate was directed by Archbishop Ildebrando Antoniutti, Apostolic Delegate to Canada.

ARKANSAS

Benefit Sponsored for St. Edward's, Fort Smith

St. Edward's Guild recently sponsored a performance by the Ballet Guild of Little Rock in order to obtain funds for the children's ward of St. Edward's Hospital, Little Rock.

CALIFORNIA

Employees of St. Francis Hospital, Los Angeles, Give Benefit Dance

A benefit dance was given recently by the employees of St. Francis Hospital, Los Angeles, as their contribution towards the hospital's expansion program.

Nearly 300 employees of the hospital and its medical staff of 200 doctors assisted in the work of selling tickets.

Sister Seraphine, Hospital Nun, Dies in San Diego

Sister Mary Seraphine of the Order of the Sisters of Mercy died recently at Mercy Hospital, San Diego.

She was born in San Francisco in 1866 and thirty-nine years later, in 1905, she entered the old Convent of Mercy in San Diego. Two years later she was professed a Nun.

Sister Seraphine was a member of the first graduating class of the old St. Joseph's School of Nursing in 1906 and spent most of her religious life in the care of the sick in Mercy Hospital, San Diego.

A Solemn Pontifical Mass of Requiem was offered in the chapel of the hospital. Interment took place in Holy Cross Cemetery.

FLORIDA

New Executive Director Named for Mercy Hospital, Miami

According to a Chancery announcement made recently, the Right Reverend Monsignor James F. Enright, who, for the past 20 years, has been pastor of St. Paul's Parish, St. Petersburg, has been appointed to the post of Executive Director of Mercy Hospital, Miami.

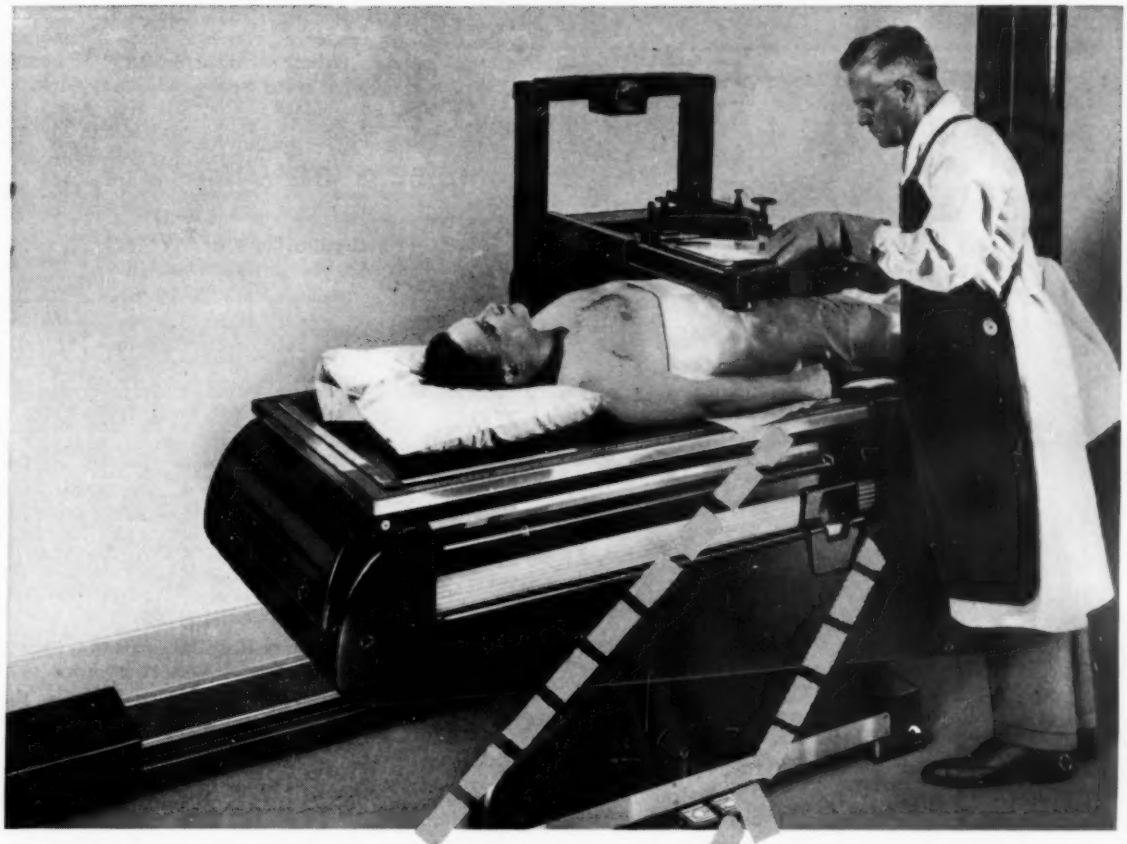
IOWA

St. Ann Hospital, Algona, Holds Organizational Meeting

Dr. C. H. Cretzmeyer, Sr., has been named to head the staff of St. Ann Hospital in Algona. He was elected by unanimous consent at the organizational meeting held recently in the staff room of the hospital.

The meeting was called at the request of the Sisters of Mercy for the purpose of organizing the medical staff and for the appointment of the hospital executive board. This board is the governing

(Continued on page 36A)



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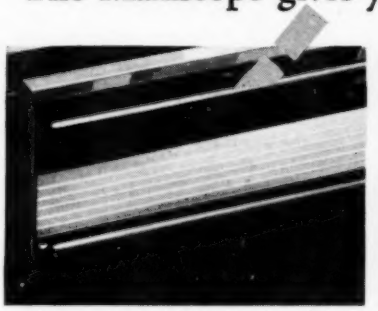
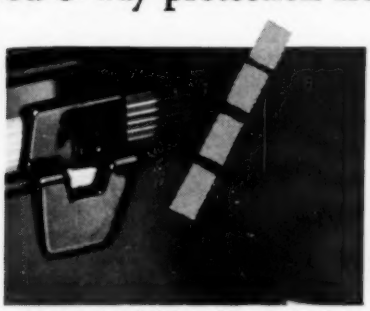


You're screened from Bucky table opening by folding shutters which operate *automatically.*



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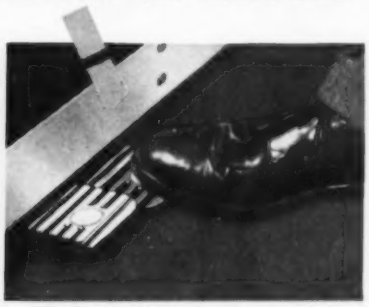

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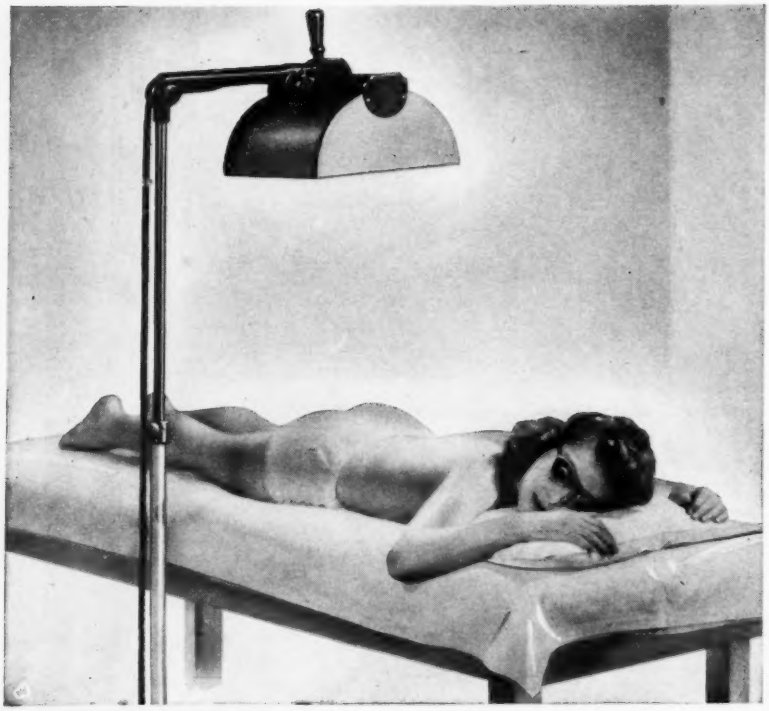

ULTRAVIOLET RICHNESS

The Burdick 'Ultra Lux' lamp, with its high vacuum mercury quartz tube, produces a spectral range high in both bactericidal and antirachitic rays.

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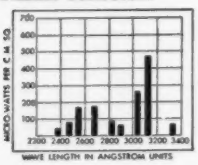


Spectral distribution of the 'Ultra Lux'

AND ECONOMY

The 'Ultra Lux' is economically priced, inexpensive to operate. Tube life is long, and experienced construction minimizes the need for replacement or repairs.

The BURDICK 'ULTRA LUX'

ULTRAVIOLET LAMP No. QA-250-N

See it at your Burdick dealer, or write The Burdick Corporation, Milton, Wisconsin, for complete information.

Burdick

THE BURDICK CORPORATION

General News

(Continued from page 34A)

unit of the hospital and has been activated to aid in settling hospital problems that may arise.

Dr. T. J. Egan of Bancroft was elected vice-president at the same meeting and Dr. M. G. Bourne of Algona was named secretary of the staff organization.

Also making up the executive board will be Dr. R. W. Lee, Algona; Dr. J. G. Clapsaddle, Burt; Sister Mary Gertrude, hospital superintendent and L. E. Linnan, Algona.

Qualifications for membership to the staff were set by the doctors present at the meeting. However, all patients will be admitted to the hospital even if their doctors are not members of the staff.

The board also decided that the radiologist for the hospital be approved by the staff.

Chaplain of Mercy Hospital, Dubuque, Is Transferred

The Reverend Francis J. Phelan, chaplain of Mercy Hospital, Dubuque, for seven years, was guest of honor at a testimonial dinner recently at Mercy prior to his leaving to become pastor of St. Mary's Church, McGregor, Ia. Among those who paid tribute to him were the Most Reverend Henry P. Rohlman, Archbishop of Dubuque.

IDAHO

Dignitaries Visit St. Valentine's, Wendell

Reverend Mother M. Jerome, O.S.B., of Sacred Heart Convent, Yankton, S D., and Reverend Mother M. Blandina, O.S.B., of St. Benedict's Convent, Crookston, Minn., recently arrived at St. Valentine's Hospital, Wendell, for a quinquennial visitation.

Reverend Mother Jerome is the Mother-President of the seven communities which make up the congregation of St. Gertrude the Great. Reverend Mother Blandina is First-Visitator of this congregation.

ILLINOIS

Columbus Hospital, Chicago, to Receive Statue Blessed by Pope

After presiding at a Mass in the Sistine Chapel, Rome, His Holiness Pope Pius XII paused long enough to bless the new marble statue of St. Frances Xavier Cabrini. The statue will be installed at the new Columbus Hospital in Chicago where the congregation of Nuns founded by Mother Cabrini are in charge.

Cook County Hospital Chaplain Observes Jubilee in Chicago

Sixty years a member of the Society of Jesus, 35 of them spent in the service of the sick and poor at Cook County Hospital, Chicago, is the record of the Reverend Francis Xavier Bimanski, S. J.

On the morning of the jubilee Father Bimanski offered a Solemn Mass of Thanksgiving. The Very Reverend John J. Clifford, S.J., of St. Mary of the Lake Seminary, delivered the sermon. A reception was held after the Mass.

Father Bimanski was born at Sion, Switzerland in 1871, entered the Society of Jesus at Blyenbeck, Holland in 1889, and was ordained at Krakow, Poland on April 17, 1904.

Immediately after his ordination, he sailed for the United States and became attached to the Buffalo mission of the Society of Jesus. In the next ten years he gave retreats and missions throughout the East and Midwest. In 1914 he was assigned as assistant chaplain at Cook County Hospital.

Chaplain of Lewis Memorial Hospital, Chicago, Dies

A Solemn Requiem Mass was held recently for the Reverend Peter F. Gall, chaplain of Lewis Memorial Ma-

(Continued on page 39A)

(Continued from page 36A)

ternity Hospital, Chicago. The Most Reverend William E. Cousins, D.D., Auxiliary Bishop of Chicago, presided at the Mass. The Right Reverend Monsignor Walter Fasnacht offered the Mass and was assisted by Reverend A. A. Freeman and Reverend Maurice Daly, C.S.V. Burial was in St. Mary Cemetery, Chicago.

A native of Chicago, Father Gall attended St. Augustine School and began his studies for the priesthood under the Franciscan Fathers at Teutopolis, Ill. He completed his philosophy and theology at St. Paul Seminary, St. Paul, Minn.

After his ordination in 1910 and until 1944 he was assigned to various churches and became chaplain at the Cenacle Convent. In 1944, he began his duties as chaplain at the Lewis Memorial Maternity Hospital, Chicago.

Medical Photography Department Set Up at St. Francis, Evanston

Sister M. Wilberta, O.S.F., administrator of St. Francis Hospital, Evanston, recently announced that a department of medical photography has been set up at the hospital. The department is under the direction of Paul Jorgensen, a graduate of the Chicago School of Photography, and it has been established in the north wing, ground floor of the hospital adjacent to the tumor clinic and the X-ray therapy department.

The St. Francis Hospital Auxiliary contributed $1,000.00 toward the purchase of modern photographic equipment to be used in this department.

New School of Technology Opened in Quincy

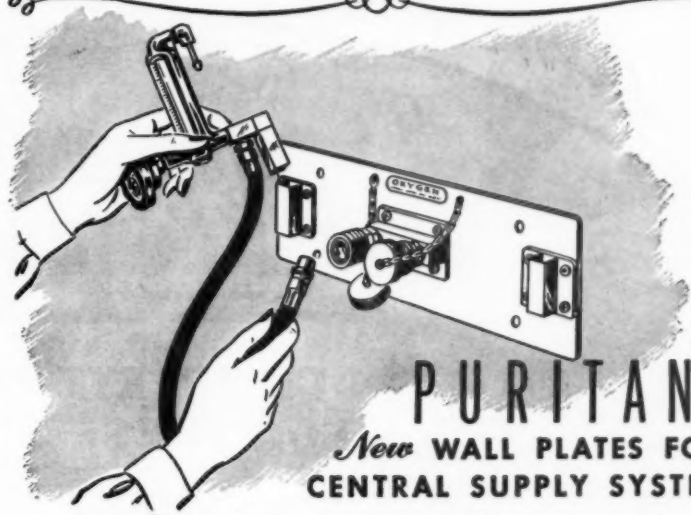
Sister M. Bathildis, administrator of St. Mary's Hospital, Quincy, recently announced the opening of a new Technology School affiliated with Quincy College.

The director of St. Mary's School of Technology is Dr. Frank Mayner, a graduate of the University of California Medical School and a pathologist, who is a diplomate in pathology. He is a member of the American Board of Pathologists.

At the completion of the course the students will receive the Bachelor of Science degree from Quincy College and will hold a certificate of registered technologist after passing the registry examination. They will also hold a diploma and a certified statement that they have spent one year in an approved laboratory.

The new school is approved by the American Medical Association and the registry of medical technologists.

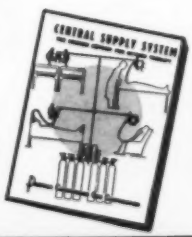
There is no finer equipment for oxygen therapy than that manufactured by Puritan



PURITAN

New WALL PLATES FOR CENTRAL SUPPLY SYSTEMS

Equipment for administration is positioned for use in a minimum of time when Puritan Wall Plates are used, and the Quick-Connector Valves provide safe connection to oxygen supply in a matter of seconds. Thus administration is simplified and the attendant freed for other duties. Wall plates are of heavy, gleaming stainless steel with chrome fittings, designed to remain firmly in place and prevent damage to walls. Single or duplex sizes available.



A copy of this new Central Supply System circular will be sent on request.

PURITAN MAID

PURITAN COMPRESSED GAS CORPORATION

Puritan Dealers in Most Principal Cities

BALTIMORE ATLANTA BOSTON CHICAGO CINCINNATI DALLAS DETROIT NEW YORK ST. LOUIS ST. PAUL KANSAS CITY

"Puritan Maid" Anesthetic, Resuscitating and Therapeutic Gases and Gas Therapy Equipment

KANSAS

Open House Held at St. Mary's, Emporia

Deep X-ray therapy lectures and demonstrations by Dr. C. P. O'Boyle, radiologist at St. Mary's Hospital, Emporia, were a feature of particular interest to visitors at the hospital's open house held recently. The value of the X-ray therapy in the fight against cancer was explained by Dr. O'Boyle.

The two additional nurseries, nearing completion on the obstetrical floor, also attracted the attention of a number of the visitors.

Among the guests who attended the open house was Mrs. Olive Taylor Jones, to whom the deep X-ray therapy department is dedicated.

Kansas Hospital Association Elects Officers in Topeka

Henry J. Meiners of Leavenworth, who has served as president-elect during the past year, was installed as president of the Kansas Hospital Association at the annual convention held in Topeka recently. Mr. Meiners, an exemplary Catholic, is superintendent at Cushing Memorial Hospital, Leavenworth, and is prominent in hospital circles in the area; he is also a member of the Board of Directors of Kansas Blue Cross.

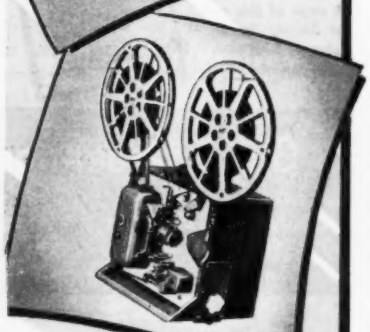
Sister Rose Irene, C.S.J., of St. Anthony's Murdock Memorial Hospital, Sabetha, was elected and will serve as president-elect of the Kansas Hospital Association this year. The president-elect

(Continued on page 42A)

FREE CONVENTION TRIPS

TELEVISION SETS

WIN ONE OF 30 IN NEW GENERAL FOODS



COMPLETE SETS OF PRIZES FOR THESE 3 MAJOR GROUPS ONE IS YOURS!

GROUP 1—Hotels, restaurants, clubs, diners, cafeterias, tearooms and similar eating places
GROUP 2—Hospitals and other institutions
GROUP 3—Industrial feeders, air lines, railway dining cars, and all others not included in Group 1 or Group 2

3 FIRST PRIZES: First prize winner in each of the 3 groups gets all-expenses-paid trip for two people to the 1950 National Restaurant Association Convention in Chicago, Ill.—May 23 thru May 26, 1950—consisting of railroad, air or bus fare, hotel for 5 days, tickets for all important official functions, and $200 spending money—*or* 100,000 prize points.

3 SECOND PRIZES: Each second prize winner gets a *choice* of a *Crosley "Family Theatre"*—big, 12½" direct-view television—AM and FM Radio—3-speed Automatic Phonograph that plays all records; *or,* a handsome *Crosley FM-AM Radio-Phonograph* with an automatic record changer, a powerful 10" concert-type PM speaker, a spacious album compartment, all enclosed in a gorgeous mahogany veneer cabinet; *or* a *Crosley 20-cubic-foot Farm Freezer, or Crosley 12.3-cubic-foot De Luxe Home Freezer; or* 75,000 prize points.

3 THIRD PRIZES: Each third prize winner gets a *choice* of an *11-cubic-foot Crosley Shelvador Refrigerator* that gives you twice as much "front-row" space and a full-width freezer that holds up to 70 lbs. of frozen foods; *or* a *Bendix Gyromatic Washer* that handles complete 9-lb. washing operation from soak to fluffing tumble after spin-drying; *or DeVry "Bantam" 16mm. Sound Motion Picture Projector, or* 50,000 prize points.

AND 21 OTHER PRIZES!

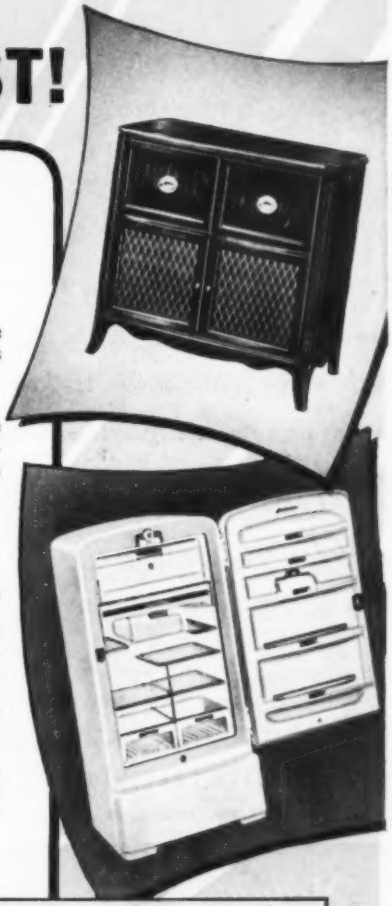
Next 7 best entries in each group receive 2,000 prize points apiece. These prize points may be applied on the hundreds of valuable prizes shown in the free Prize Catalog, or they may be redeemed for cash.

PRIZES FOR ALL! ***90 PRIZE POINTS WILL BE SENT WITH THE COMPLIMENTS OF GENERAL FOODS TO EVERYONE ENTERING THE CONTEST!***

Get your free Prize Catalog listing more than 1,000 G.F. prizes.
Write: General Foods Institution Prize Dept., Box 121, Dayton, Ohio.

RADIOS REFRIGERATORS

VALUABLE PRIZES
717,000 POINT CONTEST!



ALL OWNERS AND EMPLOYEES IN PUBLIC FEEDING INDUSTRY ELIGIBLE

HERE'S HOW YOU WIN!

1. You write a statement of *not more than* 150 words on the subject of: "Three things we do to make our eating place successful!" (See examples below!)

2. You may submit, if available, pictures, sketches, or actual samples of material described in your statement. (Desirable, but not necessary to win a prize.)

3. You may enter the contest only in the group in which your establishment is listed.

4. You fill in the entry blank on this page (or a facsimile). Warning: Be sure to indicate by check mark group in which you are entering.

5. Mail your statement and descriptive material, if available, and your entry blank to Reuben H. Donnelley Corp., nationally known contest judges.

CONTEST RULES: Contest open to owners, executives or employees of restaurants, hotels, hospitals, industrial restaurants, or other public feeding places in the Continental U. S., except employees of General Foods Corporation, its advertising agencies, and members of their immediate families.

Entries must concern the establishment with which you are associated. You may only enter group in which your establishment is listed. Statement must be your original work submitted in your own name, accompanied by a filled-in entry blank (or facsimile).

Entries must be postmarked not later than February 28, 1950. Use sufficient postage. See address below.

Entries will be judged on the sincerity and soundness of statements by Reuben H. Donnelley Corp., whose decisions are final. Duplicate prizes awarded in case of ties.

Winners will be notified by mail; their names will appear in the May issues of many Institution publications. Entries and statements become the property of General Foods Corporation to be used as it sees fit, and will not be returned. Contest subject to all Federal, State and Local regulations.

SAMPLE IDEAS SUGGEST ANSWERS SHOULD BE SPECIFIC

Below are just 4 ideas that build restaurant business. We offer them only to suggest that you make your answers brief and to-the-point. Warning! Do not copy these ideas. Originality will count heavily toward winning a prize.

1. "Our scales insure that we get what we pay for. We weigh every food item we buy."

2. "We keep a daily production chart in our hospital. Our cooks compete among themselves. The winner gets a prize."

3. "We hang a sign on our cash register announcing tomorrow's specials."

4. "We ask each patron whether he wants fast or leisurely service."

Important Contest Hints! Equal consideration will be given to all entries, elaborate or simple. It's the idea that counts. So be as *specific* as possible. And be sure your statement is not more than 150 words.

ENTRY BLANK—Fill in this entry blank or a copy and attach to each entry and statement of not more than 150 words. Mail right away.

Reuben H. Donnelley Corp.
P.O. Box 769, New York 46, N. Y.

Gentlemen: Please enter me in Group I ☐ . . . Group II ☐ . . . Group III ☐ of General Foods' 717,000 Prize Point Contest. (Check group in which you are entering.) I am submitting a statement of not more than 150 words on the subject of: "Three things we do to make our eating place successful." I am attaching to this statement, if available, pictures, sketches, or actual samples of the material described in my statement.

My Name _____ Title _____

Name of Establishment _____

Street _____

City _____ Zone _____

County _____ State _____

CODE HP

TESTS PROVE that *Medicated* Germa-Medica drastically *reduces bacterial flora* on the skin. Used regularly, its residual action keeps count down. Its low pH factor, pure vegetable oil content make it *safe, gentle on hands.*

A complete annotated bibliography on (G-11)

Write for your copy of this monograph on Hexachlorophene (G-11) *containing records of scientific tests, and complete outline of articles* in publications. Entirely free of advertising claims.

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HUNTINGTON, INDIANA · TORONTO

Medicated Germa-Medica®
with Hexachlorophene (G-11)

General News

(Continued from page 39A)

is a trustee of the Midwest Hospital Association, a member of the Hospital Blue Cross Relations Council, and is a senior member of the American Association of Hospital Accountants.

Other officers of the association are: R. A. Nettleton of Hutchinson, first vice-president; Mary Dunden of Lawrence, second vice-president; Fred M. Walters, Topeka, secretary-treasurer; Mrs. DeLora Rodeen of Topeka and Sister Frances Clare of Hays, trustees.

Annual Courtesy Dinner Held at St. Mary's, Winfield

Election of officers and a talk by Judge Albert Faulconer featured the annual courtesy dinner given by the Sisters of St. Joseph to members of St. Mary's physicians staff in Winfield.

During the election Dr. H. E. Snyder was named president; Dr. N. B. Fall, vice-president; Dr. G. L. Norris, secretary; and executive committee members: Dr. C. D. Snyder, chairman, Dr. H. H. Jones, Sr., and Dr. C. C. Hawk.

Judge Faulconer spoke to the group on the growth of medicine and the responsibility of all professional men to their communities. Dr. A. Y. Wells, retiring president, introduced the speaker.

St. Elizabeth's, Hutchinson, Elects New Staff Officers

Dr. R. A. Crawford was elected to succeed Dr. A. C. Armitage as St. Elizabeth's Hospital chief of staff at an annual meeting held in the nurses' home recently. Dr. Sam Jones was named staff vice-chief and Dr. J. B. Jarrott was named secretary.

KENTUCKY

Covington Hospital Gives Reception for New Chaplain

A reception honoring the Reverend Hugh J. Milligan, who has been appointed chaplain of St. Elizabeth Hospital, Covington, by Bishop William T. Mulloy, was given recently at the nurses' home of the hospital. The students were in charge of the entertainment program presented.

Lexington Scene of Two-Day Institute

A two-day institute for Catholic hospital representatives associated with establishments under Catholic direction in Kentucky was held recently in Lexington.

Bishop William T. Mulloy celebrated a Pontifical Mass in St. Joseph Hospital chapel, Lexington.

The Very Reverend Francis J. Connell, C.SS.R., president of Holy Redeemer College, Washington. D. C., and professor of moral theology at Catholic University of America, Washington, D. C., conducted the institute which was sponsored in conjunction with the Catholic Hospital Association.

The subject of proper ethics for Catholic hospitals and those associated with these establishments was the key theme for the two-day session.

LOUISIANA

Musser-Gordon Hospital, New Orleans, to Be Moved

Musser-Gordon Hospital for tuberculosis patients will move into buildings vacated recently by Lakeshore Hospital, New Orleans.

The transfer was confirmed by Dr. Robert Bernhard, director of Charity Hospital, New Orleans. Musser-Gordon is operated as a separate unit of Charity.

Date of the transfer has not yet been decided upon. Musser-Gordon will take over part of Lakeshore's equipment when the move is made.

New Orleans Man Honored for Hospital Work

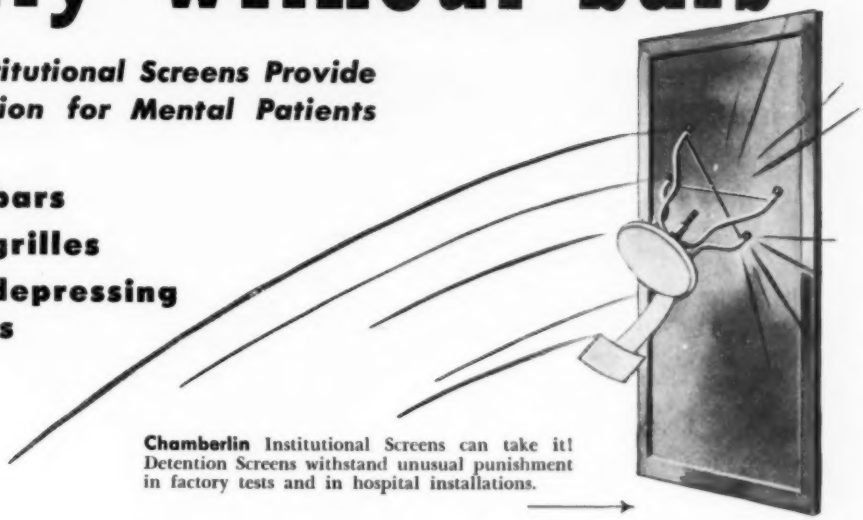
Phil McCabe, member of the St. Vincent de Paul special work committee

(Continued on page 44A)

Security without bars

Chamberlin Institutional Screens Provide Perfect Protection for Mental Patients

- **without bars**
- **without grilles**
- **without depressing influences**

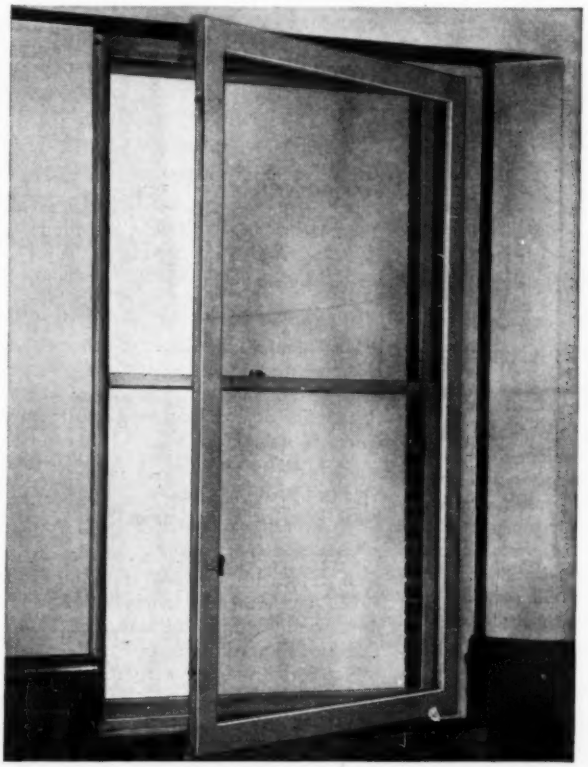


Chamberlin Institutional Screens can take it! Detention Screens withstand unusual punishment in factory tests and in hospital installations.

HOSPITAL administrators in every part of the country are calling on Chamberlin—the leader in institutional screens—to help modernize the treatment of mental patients in hospitals, old and new.

By working closely with recognized authorities on modern treatment of mental patients, Chamberlin supplies a complete line of screens that provide *all* the security of bars, *without* their hazardous, depressing influence, for all types of psychiatric cases. They also serve as efficient insect screens, eliminating duplication and additional expense.

Chamberlin's Screen Advisory Service is prepared at any time to advise you in the proper selection and installation of screens. You are invited to make use of this service without obligation. Why not do it soon?



Chamberlin Detention Screens—For maximum detention and protection without bars or grilles. Hinged frame opens with key to allow access to window for washing. Sturdy, double leaf-type springs are an exclusive Chamberlin feature to cushion all blows on screen wire.

Chamberlin Protection Screens—Recommended where less violent or disturbed patients are quartered. Sturdy and low in cost, they assure ample protection and security.

Chamberlin Safety Screens—Newest addition to Chamberlin's enlarged line, these have broad application in all hospital areas where more than ordinary insect screen security is desired.

Chamberlin Detention Screens are fitted inside all types and sizes of window openings, whether double hung, casement or other types.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY of AMERICA

Special Products Division

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Chamberlin Institutional Services

also include Rock Wool Insulation, Metal Weather Strips, All-Metal Storm Windows and Insect Screens

Essential Equipment

FOR EVERY HOSPITAL!

The Mueller Giant Eye Magnet

Powerful — Safe — Flexible
For Extraction of Iron and Steel Fragments From the Eye

Here is the most powerful magnet of its type ever built – with greater useful power than ever before – so easily controlled that it is actually a precise instrument capable of almost finger-tip delicacy in application. It is safe, sure – as simple to operate as it is free from costly maintenance – and it is not expensive. Rolls easily on noiseless casters – operates from any regular current outlet.

Particularly if you handle frequent industrial or other eye injuries, this Mueller Giant Eye Magnet is essential equipment in your hospital. No other mobile magnet has the useful power, the flexibility of this improved instrument. Smoothly, quickly adjustable for use with the patient on the operating table or chair, it is absolutely slip-proof and tip-proof, and shock-proof to both patient and operator. Mechanical operation is extremely simple and sure. The Giant Magnet is available in two models: with built-in converter, for operation on 110-volts, alternating current; and without converter, for operation on 110 volts, direct current. Complete information sent promptly upon request.

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MANUFACTURERS AND SUPPLIERS OF INSTRUMENTS AND EQUIPMENT SINCE 1895

408 SOUTH HONORE STREET CHICAGO 12, ILLINOIS

General News

(Continued from page 42A)

from St. Joseph's Parish, New Orleans, was awarded a certificate of merit recently by Mayor deLesseps S. Morrison. The document was given in appreciation of his work with children at Charity Hospital, New Orleans.

MASSACHUSETTS

Coffee Shop Blessed at St. Elizabeth's, Brighton

St. Philomena Guild's third major project for volunteer service recently got underway with the blessing by Archbishop Richard J. Cushing of the long anticipated coffee shop in the new building of St. Elizabeth's Hospital, Brighton.

Equipped with the most modern facilities, the attractive shop, catering to hospital personnel, patients and their relatives and friends, will specialize in homemade sandwiches, pastries, ice cream, coffee and tea.

Surgeons' Lounge Dedicated at St. Elizabeth's, Brighton

The surgeons' lounge in the new addition of St. Elizabeth's Hospital, Brighton, was officially dedicated recently with a tea for members of the medical staff of the hospital and their wives.

Some 250 doctors and their wives filled the lounge to hear Dr. John W. Spellman, chief of the surgical service at the hospital, discuss the various features of the new surgical suite.

Bon Secours Auxiliary Holds Sale and Tea in Lawrence

The annual gift shop sale and tea sponsored by the Bon Secours Hospital Auxiliary was attended by a large gathering of members and their friends recently when the event was held in the auditorium of St. Mary's Parish, Lawrence.

Numerous attractively-wrapped gifts and novelties, cards and paper, foodstuffs and mystery packages were offered for sale throughout the afternoon and evening.

MINNESOTA

New Breckenridge Hospital Funds Still Short

The funds for the new St. Francis Hospital to be built in Breckenrige amounts to $140,000 but $60,000 more must be raised before contracts for the building of the hospital can be let.

The Minnesota State Board of Health told the fund-raising committee that they would be given a short extension in which to try and raise the rest of the amount needed. This extension was given with the stipulation that the Board of Health be informed of the progress that has been made each week. In this way the Federal allotment was left open.

St. Joseph's Hospital, St. Paul, Willed $100,000

In her will Miss Nellie V. Bell left $100,000 to St. Joseph's Hospital, St. Paul, for a chapel to be built in memory of her brother, Daniel L. Bell, who died in 1944.

Miss Bell told the Nuns at St. Joseph's Hospital that she planned to leave money for the construction of the chapel. She died at the hospital after an illness of six weeks.

St. Paul Province Has New Provincial Assistant

Sister St. Ignatius, former superintendent at St. Joseph's Hospital, St. Paul, was recently named assistant provincial superior of the St. Paul Province of the Sisters of St. Joseph.

Sister received her early training in nursing education at St. Mary's Hospital, Minneapolis, Minn. before entering the Community of the Sisters of St. Joseph. She was superintendent of nurses at St. Mary's Hospital from 1917

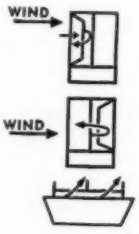
(Continued on page 46A)

CONTROL fresh air

with this modern, built-in "appliance"

The patient's condition . . . outdoor temperatures . . . wind direction . . . these and other variables affect the amount of air you want and how to bring it in.

*Fenestra** Intermediate Combination Steel Windows are designed to meet varied conditions. The nurse, with one hand, twirls a geared adjuster and the casement leaf swings out to the desired position—and stays there. She can select almost any degree of ventilation.



For gentle air movement: She "backs" one vent against the wind.

To scoop in air: She swings one vent out so its "edge" cuts into the wind stream.

For ventilation without drafts: She opens the sill vent, which deflects incoming air upward. This vent is particularly valuable in providing ventilation during rain.

Fenestra Windows bring in more daylight, too, for they provide more glass area than windows with bulky frames and members. They're precision-made windows that save maintenance. They're screened and cleaned—all from *inside.*

These beautiful windows are easy on building budgets—for they are standardized to keep first cost and installation costs down.

Their quality is assured by Fenestra's experience as America's oldest and largest manufacturer of steel windows. *®

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In WOOD STEEL furniture only the actual damaged part need be replaced — it's done quickly at low cost — truly furniture made for rough handling, WOOD STEEL furniture combines the beauty and richness of wood, plus the strength and durability of steel . . . climate and extreme humidity cannot affect WOOD STEEL furniture, as there are no glued joints to fail . . . drawers cannot stick nor swell.

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Wood Steel Products Co.

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NEW YORK SHOWROOM: 31 West 57th Street
Phone: PL 9-3374 — PL 9-3375

General News

(Continued from page 44A)

to 1926, and much of her later work was done at St. Mary's, where she was general supervisor of surgery and of anesthesia. She spent three different intervals at Trinity Hospital, Jamestown, N. D., in this same type of work.

Appointed assistant supervisor at St. Mary's Hospital, Minneapolis in 1936, she remained there until 1938 when she became superintendent and superior of Trinity Hospital, Jamestown, N. D. In 1941 she was appointed to the same positions at St. Joseph's Hospital, St. Paul, Minn. and remained there until 1947.

MISSOURI

Benefit Ball Given in Cape Girardeau

Net proceeds from the recent Firemen's Ball, which will be used for the purchase of equipment for the St. Francis Hospital physical therapy center, Cape Girardeau, totaled $948.09.

The proceeds this year are more than twice those of the 1948 ball. Firemen and members of the Junior Chamber, joint sponsors of the affair, sold 1111 tickets for a total of $1387.75. Expenses amounted to $693.70. Concessions brought in $254.04.

St. Francis, Maryville, Sponsors Benefit Bazaar

A benefit bazaar, sponsored by the Sisters of St. Francis was held recently for the purpose of obtaining funds for new X-ray equipment at St. Francis Hospital, Maryville.

Prizes at the bazaar included an automatic electric toaster, a portable radio and an embroidered luncheon set.

St. Anthony's, St. Louis, Receives Two Gifts

The B.P.O. Elks Lodge No. 9 of St. Louis recently donated a wheel chair to St. Anthony's Hospital and $500 in cash to the polio fund drive.

Sister Hyacinth and Dr. M. Glaser, both of St. Anthony's, received the gifts from John C. Kappel, Jr. and Robert C. Connelly, representatives of the lodge.

St. Louis University Receives Federal Grant

A Public Health Service grant for cancer research to St. Louis University School of Medicine was announced recently by Federal Security Administrator Oscar R. Ewing.

(Continued on page 49A)

Make Sunday a Bright Day for Your Patients with

Special Sunday Tray Appointments

Here's an easy way to show your interest in your patients' well being. Use Aatell & Jones special Sunday paper napkins and tray covers. Sunday is a bright spot in your patients' week with these cheerful, colorful paper tray appointments adding an attractive note to the meals.

Bright, cheerful surroundings do much in speeding a patient's recovery. Aatell & Jones holiday and Sunday paper tray appointments, through their lively and colorful designs, lift patients' morale. They mean more sanitary service, too, with a clean new tray cover for each serving.

Order NOW for immediate delivery.

Aatell & Jones, Inc.

3360 FRANKFORD AVE.
PHILADELPHIA 34, PA

(Continued from page 46A)

The grant of $4000 is for a study by Nobel prize winner Dr. E. A. Doisy, tracing, with the aid of radioactive carbon, the passage of cortisone through the bodies of laboratory animals.

MONTANA

Hospital Guild Benefits St. John's in Helena

One of the most outstanding improvements at St. John's Hospital, Helena, during the last year was the construction of a new nurses' cafeteria and adjoining service portion on the ground floor of the building. This new cafeteria was constructed through the efforts of the hospital's guild.

With a seating capacity of 72, the new cafeteria features cool pastel green walls as well as venetian blinds, print drapes in light green, red and beige and glistening beige and brown linoleum.

Eighteen chrome pedestal tables with pastel green formica tops and matching chrome chairs with beige seats and backs comprise the furnishings in the dining room. Fluorescent lighting fixtures have been installed as well as three stainless steel coffee stations and stainless steel cream dispensers.

The service portion of the cafeteria, also done in green and beige, is equipped with a stainless steel double sink unit, preparation tables, cabinets for storing dishes and utensils and electric serving table. Green tile has been used between the sink and cabinets for cleaning equipment and a large refrigerator.

Food is prepared in the main hospital kitchen and brought to the cafeteria.

Since its founding in 1937 the guild has purchased much needed equipment for St. John's Hospital. In 1938 they bought a baby incubator and a basal metabolism machine. Each year since has seen equipment added to the properties of the hospital through the efforts of the guild.

The guild also sponsors an annual dance from which proceeds are used to purchase equipment and supplies.

In addition to the monetary service the guild maintains standing committees which provide library and visiting service to those hospitalized. Tray decorations for various holidays are fashioned. a committee sews items for the nursery and repairs worn linens and surgical and hospital linens, and another committee provides welfare services of various types.

NEBRASKA

Miss V. Davis Receives Omaha Hospital Appointment

Sister Mary John, R.S.M., administrator at St. Catherine's Hospital, Omaha, recently announced the appointment of Miss Vesta Davis as dietitian at the hospital.

Sister Mary Kevin, R.S.M., director of St. Catherine's Hospital School of Nursing said that Miss Davis will serve also as an instructor in dietherapy.

Nineteen Sisters Attend X-Ray Course in Omaha

Nineteen Catholic Sisters from Nebraska, South Dakota, Iowa and Minnesota, and one from Mexico City, D. F., were in attendance at the annual short course on X-ray technique given recently at Creighton Memorial St. Joseph's Hospital, Omaha.

In charge of the institute was H. O. Mahoney, Milwaukeee, Wis., an instructor of X-ray technique. He was assisted by Leo D. Kane.

Personnel Changes Made at St. Joseph's, Omaha

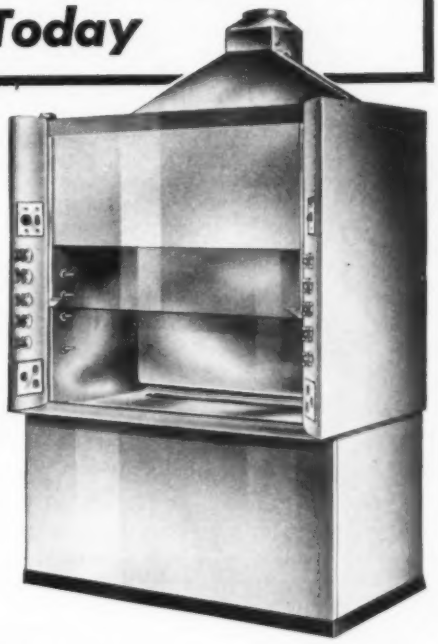
A series of changes involving hospitals operated by the Poor Sisters of Saint Francis Seraph in the Archdiocese of Omaha were announced recently by Venerable Mother M. Reginalda, O.S.F.,

(Continued on page 50A)

The FUME HOOD of the FUTURE . . is Yours Today

Kewaunee's New LOW VELOCITY FUME HOOD for Handling RADIO-ACTIVE ISOTOPES

Design Approved for Use by the OAK RIDGE INSTITUTE of NUCLEAR STUDIES



No. 3600—Kewaunee's "FUME HOOD of the FUTURE"

The Hood is made with stainless steel interiors and ducts throughout and incorporates a stainless steel working surface and trough. The working surface will support a load of 4,000 pounds. The Hood incorporates a new system of airfoils, baffles and ducts which provides a uniform flow of air over the entire face of the Hood, thus assuring evacuation of gases at extremely low velocities without interference from reverse eddies or turbulence. No auxiliary duplicate duct system for incoming air is required.

Write for Descriptive Literature and Drawings available now on Kewaunee No. 3600—"The Fume Hood of the Future"

Kewaunee Mfg. Co.
C. G. Campbell, President
5022 S. Center Street Adrian, Michigan
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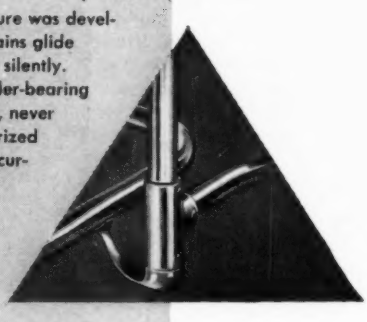
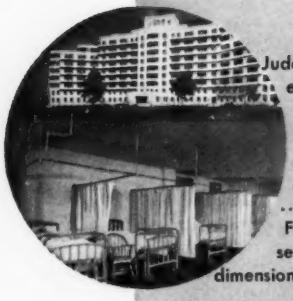
QUALIFIED BY OVER 20 YEARS EXPERIENCE

in perfecting cubicle equipment

This patented corner fixture was developed by Judd to let curtains glide around corners instantly, silently. Judd's fiber-wheeled, roller-bearing carriers are always quiet, never jam. Judd's sturdy Sanforized white or colorfast pastel curtains have rustproof grommets permanently machined into top hem.



...in satisfying hospital needs



Judd's strong, durable cubicle equipment is easy to install and maintain. And you can depend on Judd's efficient planning to use space to best advantage ...keep costs at a minimum. For a costfree estimate, just send a simple diagram, with dimensions, of areas to be cubicled.

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General News

(Continued from page 49A)

supervisor of the obstetrical department at St. Joseph's Hospital, Omaha, has been appointed to the office as second assistant superior. Sister M. Edmondine Kudlacz, formerly in the medical records department at St. Joseph's and more recently at St. Anthony Hospital, Denver, has assumed her new duties at St. Mary's Hospital, Columbus, in a similar assignment. Sister M. Philonilla, O.S.F., R.N., is the new night supervisor at Good Samaritan Hospital, Kearney, succeeding Sister M. Salvatora, O.S.F., R.N., who has assumed charge of the new central service department at the same institution.

Other changes affecting St. Joseph's Hospital include the transfer of Sister M. Simpliciana, laundry supervisor to St. Francis Hospital, Grand Island, in an exchange of positions with Sister M. Leonardis. Likewise, Sister M. Annetta, formerly head of the linen and sewing department at St. Joseph's, has gone to St. Joseph Convent, Denver, exchanging posts with Sister M. Lucila.

Sister M. Corneliana, O.S.F., R.N., provincial superioress of St. Joseph Convent, Denver.

NEW JERSEY

Benefit Boxing Show Given for Camden Hospital

A crowd of more than 3000 fans attended a benefit boxing show held recently for Our Lady of Lourdes Hospital Fund given by the Camden Chapter Police Benevolent Association, Local 35.

At the intermission, following the fifth fight, James Halpin, representing Monsignor Joseph B. McIntyre, chairman of Our Lady of Lourdes Hospital Fund committee, expressed his thanks to all present.

Camden Hospital Fund Drive Totals $104,222

J. K. West, chairman of the executive committee directing the campaign for Our Lady of Lourdes Hospital, Camden, recently announced that contributions amounting to $104,222 have been made to the equipment fund drive for the hospital.

Dr. Thomas M. Kain, of the special industry committee, announced two major contributions which put the drive past the one-third mark.

One was a donation of $10,250 from the Campbell Soup Company which previously gave $35,750 to the building fund. The other was a pledge of $2000 a year for five years by Louis and Thomas Bantivoglio, president and treasurer, respectively, of N. Bantivoglio's Sons, Inc. They also presented the hospital with an ambulance.

The drive has a goal of $310,000. This amount is needed to furnish and equip the eight-story hospital building nearing completion. The hospital is costing a total of $4,560,000.

NEW YORK

Albany Doctor to Direct Commission on Chronic Illness

Dr. Morton L. Levin, assistant commissioner for medical services of the New York State Department of Health, has been appointed director of the Commission on Chronic Illness.

Announcement of the appointment was made recently by Leonard W. Mayo of New York, chairman of the commission and general director of the Association for the Aid of Crippled Children in New York City.

The commission is located at the headquarters of the American Medical Association in Chicago. Dr. Levin has been granted leave of absence from his present post.

Cathedral Mass Marks Centenary of St. Vincent's, New York City

His Eminence Francis Cardinal Spellman recently celebrated a Solemn Pon-

(Continued on page 52A)

"Mother and Child doing nicely"

To the world outside the hospital the birth and care of an infant may be mostly heart throbs. Within the hospital it is hard work and meticulous attention to details.

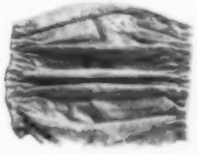
The work will be easier, the details will give fewer headaches if supplies and equipment are adequate and dependable.

It is distinctly not our business to advocate any particular techniques. But it is our business to keep abreast of developments and be ready to provide you with the best equipment and supplies to meet your special demands — Delivery Tables, Nursing Bottles, Nipples — inexpensive Bassinet Stands or complete "rooming-in" Bassinets — Breast Binders or Baby Beads — whatever you need to make it easier to report, "Mother and Child doing nicely." This is a job we have enjoyed doing for more than 35 years.

SAFE CAPS FOR ALL TYPES OF NURSING BOTTLES

KENWOOD BABY BEADS

INFANTS' GOWNS



DISPOSABLE DIAPERS

HEAT RESISTANT NURSING BOTTLES

BASSINET STAND AND BASKET

WILL ROSS, INC.

Manufacturers and Distributors of Hospital and Sanatorium Supplies and Equipment

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Minimize Trauma, Pain and Leakage

Conventional hypodermic needles are like miniature biopsy needles—they cut out tiny cylinders of tissue removing nerve elements. In tissue so traumatized, pain lingers and the medication may leak out along the path of the needle.

The rapier-points and rounded edges of "Blue Label" Needles are designed to penetrate by parting rather than by painfully slicing tissue fibers. Rapier-points are stronger—stay sharp longer because they contain more metal than conventional needles. These hand-honed needles are subjected to painstaking control and inspection at every stage of manufacture to insure freedom from chips, burrs and abrasives. Thus, "Blue Label" Needles offer hospitals definite savings in time and money. Why not order a supply today from your nearest surgical supply dealer? J. Bishop & Co. Platinum Works, Medical Products Division, Malvern, Pa. In Canada: Johnson Matthey & Mallory Co., Ltd., 110 Industry Street, Mt. Dennis, Toronto 16.

BISHOP "BLUE LABEL" NEEDLES

Made of 18-8, the safe stainless steel

SERVICE TO SCIENCE AND INDUSTRY SINCE 1842

General News

(Continued from page 50A)

tifical Mass in St. Patrick's Cathedral in honor of the 100th anniversary of the founding of St. Vincent's Hospital, New York City.

St. Vincent's, when it opened the doors of its original building, was the first free hospital in New York City and the first Catholic hospital in the archdiocese. Originally the hospital was staffed by four Sisters of Charity of St. Vincent de Paul and had accommodations for only 30 patients. Last year the staff of highly-trained Sisters, doctors and nurses cared for 13,268 hospitalized patients as well as 29,804 emergency cases.

Archbishop Hughes founded St. Vincent's Hospital in order to fill a desperate need for a free hospital to care for the sick poor. At the time cholera and typhoid were taking a heavy toll among the poor immigrants in New York.

During its 100 years under the Sisters of Charity of Mount St. Vincent, St. Vincent's has expanded from one small brick building to four towering buildings. The hospital's Archbishop Spellman Pavilion, built in 1941, and the Alfred E. Smith Memorial Hospital, to be completed in April at a cost of $5,000,000 are among the most modern hospital structures in the world.

Physician of St. Vincent's, New York City, Dies

Dr. John F. McGrath, 63, who had practiced medicine in New York for 40 years and was director of obstetrics and gynecology at St. Vincent's Hospital, New York City, died recently at the hospital after an illness of three days.

He was born in Holyoke, Mass., received his medical degree from Cornell University Medical College in 1908 and had been a member of the staff of St. Vincent's Hospital for 40 years. For more than 30 years he had taught at Cornell Medical College, where he was assistant professor of obstetrics and gynecology at the time of his death.

Dr. McGrath was a member of the Harvey Society, the Alumni Society of Bellevue, the New York County Medical Society, the New York Medical-Surgical Society and the New York Academy of Medicine. He was a fellow of the American College of Surgeons and a member of the Knights of Columbus.

Woman Doctor of St. Vincent's, New York City, Wins Award

Dr. Virginia Connolly Mitty, currently senior resident physician in pediatrics at St. Vincent's Hospital, New York City, recently received the award of the Medallion of Honor of the Women's International Exposition during the opening ceremonies in New York. Dr. Mitty was selected by a group of 30 Catholic lay organizations as their "Ideal Career Girl for 1949."

The "Ideal Career Girl" project has been set up by the Women's National Institute, which sponsors the exposition annually, to encourage the younger career girl, between the ages of 20 and 30, by giving her recognition for achievements in the field of her choice. Selected organizations are invited each year to participate in the project and to choose from their membership a girl to be honored as their "ideal" for that year. Selections are made by each organization according to a stipulated list of qualifications.

St. Mary's, Rochester, to Expand Radiology Facilities

As part of the $6,940,000 program for modernizing and enlarging Rochester's voluntary hospital system, St. Mary's Hospital radiology department is to be expanded.

NEW MEXICO

Hypo Sterlizer Donated to Holy Cross Hospital, Taso

Holy Cross Hospital, Taso, recently received a new hypo sterilizer from the

(Continued on page 55A)

HYDROTHERAPY

COMBINATION ARM, LEG & HIP UNIT
Mobile Model HM 200
(An Improved Whirlpool Bath)

FULL BODY IMMERSION HYDROTHERAPY TANK UNIT
Model HM 801

All the advantages of aqueous conductive heat with mild, sedative underwater massage

In physical medicine, Ille equipment is more and more the preferred choice of specialists and hospitals alike. Precision engineering "builds" into each Ille unit a high degree of efficiency, safety and economy of operation—such important considerations in equipment designed to relieve pain and disability and improve function. Descriptive literature and medical reprints readily available.

ILLE HYDROMASSAGE
SUBAQUA THERAPY EQUIPMENT

OTHER ILLE UNITS: New Improved Paraffin Bath, Mobile Sitz Bath, Folding Thermostatic Bed Tent, etc.

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AMERICAN MEDICAL ASSOCIATION

ILLE
ELECTRIC CORPORATION
36-08 THIRTY-THIRD STREET
LONG ISLAND CITY, N. Y.

UL

Geneval News

(Continued from page 52A)

hospital's auxiliary who voted to purchase it. It is one of the several items which have been on the waiting list for some time, but had to be postponed because of the greater need for the emergency water tank, installation of which was the auxiliary's chief project since its reorganization last year.

While the auxiliary's present project is to provide funds for expensive drugs for treatment of needy persons at the hospital, it will continue to use membership dues for purchase of articles badly needed at the hospital. Among these are an additional O.B. table, youth bed and child's wheelchair.

OKLAHOMA

Former Superintendent Again Heads Oklahoma City Hospital

Sister Mary Agnes Friday is once more superintendent of St. Anthony's Hospital, Oklahoma City.

The veteran Nun, who has spent the last 29 years serving Oklahomans at the pioneer Catholic hospital, first served as superintendent from 1941 to 1942. All appointments to this post are on a three-year basis.

OREGON

Club Donates Oxygen Tent to St. Elizabeth's, Baker

The Baker Soroptimist Club recently donated an oxygen tent to St. Elizabeth's Hospital, Baker, with funds raised by various means, the most successful venture being a Donnybrooke Fair.

The three machines which the hospital has been using take approximately 10 minutes to be set up, but the new machine can be made ready for patients in two minutes.

Greatest advantage of the new oxygen tent is that it is self-refrigerating. This not only saves the hospital's ice bill but it eliminates the need of an attendent constantly at the bedside, insuring that the old style oxygen tent has enough ice in its jacket to keep the motor from overheating.

A small tube is close at hand and readily available, telling the attendant just how much oxygen is being dispersed through a connecting pipe into the interior of a covering resembling a cellophane wrapping.

The machine, valued at $600 was on public display for several days at the hospital. The hospital personnel showed their gratitude to the Soroptimists by staging a small party for the Club.

PENNSYLVANIA

Medical Mission Nun Leaves Philadelphia for East Pakistan

Traditional departure ceremonies were held recently at St. John's Church, Philadelphia, for Sister M. Francis Webster, M.D., a Medical Mission Sister. Sister Francis with two other Sisters left for East Pakistan where she will be staff physician and surgeon at Holy Family Hospital.

After her entrance into the Society of Catholic Medical Missionaries, Sister Francis studied medicine at Women's Medical College of Philadelphia, and then spent one year as an intern at Mary Immaculate Hospital, Jamaica.

SOUTH DAKOTA

Funeral Services Held in Aberdeen for Hospital Nun

Funeral services were held recently in the Presentation Convent Chapel, Aberdeen for Sister M. DeChantel who died at St. Joseph's Hospital, Mitchell.

Sister DeChantel was born in 1883 in the county of Monohan, Ireland. After arriving in this country in 1913, she entered the Presentation community at Aberdeen. She worked several years as a nurse at McKennan Hospital in Sioux Falls. For the past 23 years she had been stationed at St. Joseph's.

SEPTISOL
ANTISEPTIC LIQUID SOAP
containing HEXACHLOROPHENE (2% Basis Soap*) in a Non-Irritating Soap Base

Over 10,000,000 surgical scrubs in over 1,000 hospitals have proven that . . . in SEPTISOL the full antiseptic action of HEXACHLOROPHENE (G-11**) is available to provide:

- Surgical wash times sharply reduced . . . With regular use, hands are bacteriologically cleaner after 2 minutes of washing than after a 10 minute conventional scrub with ordinary soaps.
- Elimination of brush scrubbing and antiseptic after-rinses.

Extensive use in hospitals has proven these additional advantages . . .

- SEPTISOL is non-irritating to normal skin . . . low pH and emollient in SEPTISOL prevent keratolytic action and "soap-irritation."
- SEPTISOL makes a rich lather—lubricates the skin.
- Natural vegetable emollient in SEPTISOL leaves the hands soft and clean; no greasy film of petrolatum or other mineral derivatives.
- Less HEXACHLOROPHENE (G-11) is required in SEPTISOL than in a soapless base—thus reducing any toxicity factor.

*Reports in the authoritative medical literature have repeatedly confirmed the effectiveness of HEXACHLOROPHENE (G-11) in soap in the concentration of 2% of the soap content. Write for information on bacteriologic tests. **Trademark of Sindar Corp.

A professional sample will be mailed upon request.

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New Supplies and Equipment

Production, Service, and Sales News for Hospital Buyers

Finish Remover

Removal of old finishes, always a headache for the maintenance man, especially on floors or surfaces where further sanding is not possible, has been made much easier by a new product developed by Huntington Laboratories. The solvent, Wade Seal Remover, is a heavy-bodied liquid that is claimed effective in removing old seals, varnishes, and other finishes from wood floors, walls or woodwork, and from desks and fine furniture.

It is noninflammable, nonexplosive, and will not damage the grain or discolor the finest wood because it contains no alkali, water, wood alcohol, acids, or lye.

For further information write to *Huntington Laboratories, Inc., Huntington, Ind.*

For brief reference use HP—0200.

Asthma Relief

Abbot Laboratory has introduced Norisodrine Sulfate for the reduction of bronchospasm in asthma. Norisodrine is similar to epinephrine and ephedrine chemically, but it exhibits some differences in pharmacological activity. Two powder formulas, 10 per cent and 25 per cent for oral inhalation, are available in Aerohalor Cartridges. Norisodrine Sulfate Solution 1:100 is for use in a hand nebulizer or by oxygen aerosolization.

Norisodrine Sulfate 10 per cent powder is indicated for the relief of mild or moderate acute attacks of asthma. Norisodrine 25 per cent powder is indicated in severe attacks of asthma and in *status asthmaticus*. Dosage and frequency of administration must be cautiously and carefully adjusted.

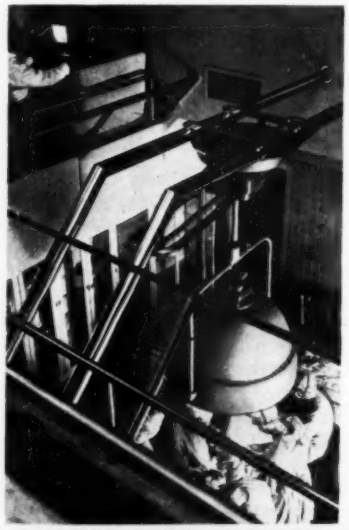
For further information write to *Abbot Laboratories, North Chicago, Ill.*

For brief reference use HP—0201.

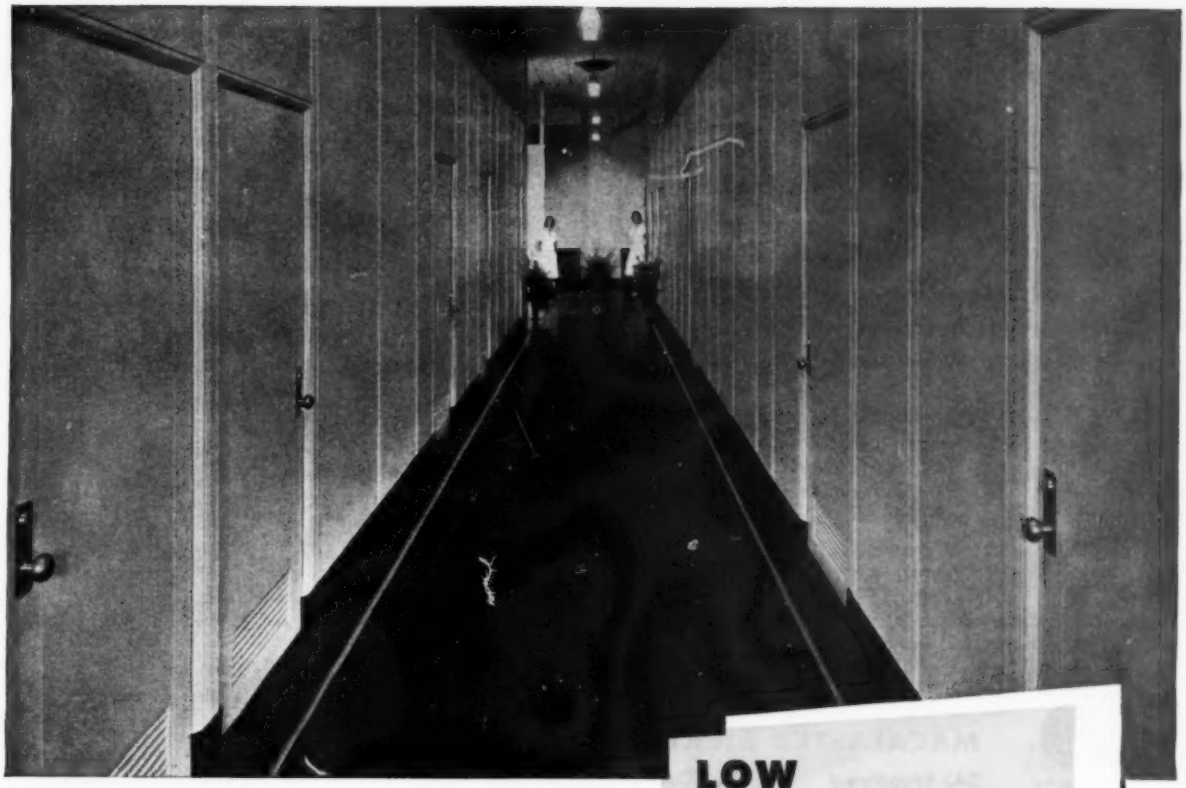
Medical Television

On Sept. 20, 1949, at the University of Kansas Hospital, medical students, doctors, and nurses watched a

(Continued on page 58A)



Medical Television. Upper picture shows the operating room; lower picture shows students viewing the operation in another room.



This Hospital is Endowed with LOW MAINTENANCE COSTS

PATCHING and repainting ordinary hospital walls is a never-ending expense. But hospitals having Hauserman *Movable* Steel Interiors virtually eliminate this constant maintenance cost.

That's because Hauserman *Movable* Steel Interiors have a baked-on finish that won't chip, crack, warp or scale. This eliminates frequent patching and repainting. It means that a janitor can easily perform all the normal maintenance required . . . occasional soap and water washing.

Hauserman *Movable* Steel Interiors also assure efficient operation for the life of the building. Hauserman Steel Partitions can be easily moved whenever alterations or additions will make new floor layouts desirable.

A Hauserman representative will be glad to discuss these and all the other advantages of Hauserman *Movable* Steel Interiors with you, your architect and your contractor. Just call the Hauserman office or representative nearby or contact *The E. F. Hauserman Company, 6963 Grant Avenue, Cleveland 5, Ohio.* Or, if you prefer, we'll send you our fully illustrated 60 page catalog.

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HAUSERMAN
Movable Steel Interiors

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Logically . . . You'll want to eliminate outmoded technics and equipment with

POUR-O-VAC SEALS

the modern, reusable hermetic closure for sealing, storing, handling and conserving surgical fluids.

THESE FACTS ARE CONVINCING . . .

Pour-o-vac Seals eliminate the possibility of sterile water contamination caused by intake of bacteria-laden dust . . . avoids contamination by unfiltered air.

They serve a secondary function of providing a dustproof seal for remaining fluid when only the partial contents of a container are used. Of importance, they are interchangeable with all Fenwal 3000, 2000, 1000 and 500 ml. containers.

In permitting contents to be stored for long periods under vacuum . . . periodic testing for sterility without breaking the hermetic seal . . . pouring of contents from a non-drip sterile lip, Pour-o-vac seals eliminate the wasteful, time-consuming and questionably scientific method of sealing with gauze, cotton, paper, string and tape.

ORDER TODAY or write immediately for further information

Fenwal

MACALASTER BICKNELL COMPANY

243 Broadway **Cambridge, Massachusetts**

New Supplies

(Continued from page 56A)

hernia operation and a gall bladder removal and heard the operating surgeons explain every step of the operation performed in another building five stories away.

This telecast was particularly significant from the medical standpoint because no camera men or television technicians were in the operating room, only the operating team was in the sterile area. The surgeon was also equipped with a headphone to pick up questions from students who could ask them through a traveling microphone in the viewing room.

The new process was due to the combined efforts of Remington Rand and the Wilmot Castle Company who developed the new Castle operating light, only slightly larger than normal. The Castle light was developed to contain in its housing the camera and microphone, necessary transmitting cables, and all the other equipment necessary to pick up image and sound without sacrificing the illumination and mobility required to give adequate surgery lighting. That this was accomplished is evidenced by the success of this telecast from the first permanent installation of *Video* for teaching in any medical school or hospital in the nation.

For more information write to the *Wilmot Castle Co., Rochester, N. Y.*

For brief reference use HP—0202.

Plasma Ready for Use

Normal Human Plasma (Coutland) requires no complicated dispensing sets. It comes with built-in stainless-steel filter. It is restored to liquid state in one to three minutes and is available through *American Hospital Supply Corp., Evanston, Ill.*

For brief reference use HP—0203.

Weck Salesmen

The Edward Weck Company, Brooklyn, N. Y., has announced several changes in its sales personnel. James Walton, who had been in the order department for ten years, has joined the sales staff and will cover Brooklyn, Jamaica, and Long Island City Hospitals.

Felix Bronneck's territory has been extended and now includes Long Island, parts of New Jersey, down the shore, Philadalphia, and northern Delaware and Maryland.

Surgical Progress

An illuminated display depicting the progress of surgery through the ages has been presented to the Smithsonian

(Continued on page 60A)

Normal Human Plasma (Courtland) requires no complicated dispensing sets.

ACCEPTED AND PROVED BY 1500 HOSPITALS!

This Positive System of Patient Identification

A Soft Pliable Bracelet Contains Patient's Name (Permanently attached to patient's wrist)

The Presco Identification System is the FIRST new practical system of identfying hospital patients, both adults and babies. More than 1500 hospital are using the Presco System of Identification. Easy to use . . . a soft pliable bracelet contains the patient's name and is slipped around the wrist or ankle. It is one sure way of identification.

HOW IT WORKS

Contains all the necessary materials to make 144 bracelets. Adjustable strips fit any size wrist. Name cards are slipped into the transparent plastic bracelet. There is room enough to include such identification as the patient's address, physician, fingerprint, etc. It cannot come off unless it is cut off.

IDEAL FOR ADULT PATIENTS

All hospital administrators are familiar with the possibility of mistakes in giving medicines and treatments, in removing patients from original beds without proper transfer of bed tags, charts, etc., and mistakes caused by "drowsy" and foreign-nationality patients who fail to understand questions being asked. The Presco Bracelet is recommended for use in multiple-bed rooms, surgical cases, pediatrics, the morgue, and many other applications.

PAT. PEND.

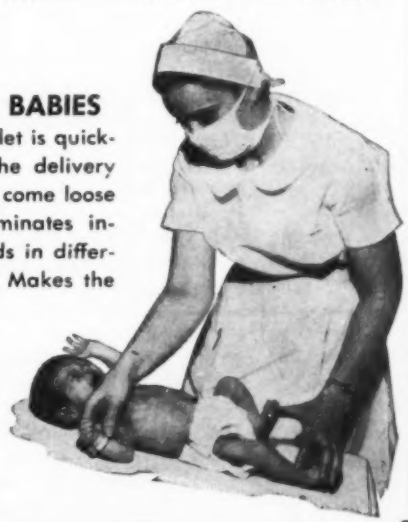
BRACELET MEASURES ⅜" WIDE

BUY THIS COMPLETE KIT:

This plastic kit contains all necessary materials, including: 144 complete bracelet-anklets (72 blue and 72 pink . . . adult bracelet also comes in all pink, all blue and all white), 1 pair 4½" (chromed) surgical scissors, 2 pencils.....$59.75
Refills are packed as follows: 144 complete bracelets packed same as above.....$43.20

IDEAL FOR BABIES

The Presco braclet is quickly applied in the delivery room . . . cannot come loose or slip off. Eliminates inventory of beads in different initials, etc. Makes the nurse's job easier. It provides a keepsake for the mother.



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WILL ROSS, INC.
3100 W. Center St., Milwaukee 10, Wisc.

NOW UNDER CONSTRUCTION

Divine Providence Hospital, Williamsport, Pa., Now Nearing Completion

A SECOND LAWSON ASSOCIATES CAMPAIGN

B. H. LAWSON ASSOCIATES directed a successful campaign to raise $700,000 for Divine Providence Hospital, in Williamsport, Pennsylvania, in 1945. More than $751,000 was subscribed in cash and pledges.

The Sisters of Christian Charity decided, however, to await more favorable building conditions. They also revised their original plans to provide 225 beds and other added facilities for the care of the sick. The total estimated cost under the new plans is $3,000,000 and the Sisters have increased their pledge to $1,700,000.

A campaign to raise the $600,000 needed to complete the hospital is now in progress.

Recalling the success of the 1945 fund-raising effort under LAWSON ASSOCIATES direction, the Sisters retained this firm for the present campaign, the object of which is to "open the doors" of Divine Providence Hospital in 1950.

A LAWSON ASSOCIATES campaign for a Catholic hospital or other institution is planned to obtain maximum gifts, not only from Catholics but from the whole community. If you need funds, why not investigate our services?

Our brochure, "Fund Raising for the Church," is available without obligation on request to Department E-1

B. H. LAWSON ASSOCIATES
INCORPORATED
307 Sunrise Highway Rockville Centre, New York

New Supplies

(Continued from page 58A)

Institution by Davis & Geck, Inc., of Brooklyn, N. Y., suture manufacturing subsidiary of the American Cyanamid Company. This exhibit is based on a series of photographs prepared by Lejaren a Hiller, noted artist and photographer, dramatizing events in the lives of many of the noted doctors and surgeons of an earlier period, who did much to make possible the complicated procedures so commonplace in the modern hospital and operating room.

Maxitron X-ray

General Electric has developed a new X-ray therapy machine, called the Maxitron because the unit not only has a phenomenal output of X-radiation compared with earlier machines in the field, but also produces the widest range of radiation ever produced by a single X-ray treatment unit. The high radiation output makes it possible to treat twice as many patients per day as on equipment of earlier design. Use of a new-type tube, with a beryllium window or exit port, makes it possible for the machine to treat many different kinds of conditions, ranging from skin ailments, where nonpenetrating radiation is required, to deep-seated cancers, which require highly penetrating rays.

For information write to the *General Electric X-Ray Corp., 4855 Electric Ave., Milwaukee 14, Wis.*

For brief reference use HP—0204.

Stainless Steel Safety Pin

Debs Hospital Supplies has introduced a new Stainless Steel Safety Pin that is said to have the sharpest point of any pin and with the piercing qualities of a needle. The tensile strength of stainless steel enables the pins to be made from wire of narrower diameter with the same comparative strength as other pins. This offers less resistance and means easier piercing. Because of its hardness the points can be made smoother and can be polished. A wider spring opening means the pin will hold more firmly when fastened. The pin has high non-corrosive qualities, and resistance to iodine, bichloride of mercury, and to high temperature autoclaving.

For information write to *Debs Hospital Supplies, Inc., 118 S. Clinton St., Chicago 6, Ill.*

For brief reference use HP—0205.

Nutrition Book

A new book, *Nutrition Data,* prepared for distribution to physicians and professional nutritionists, is now being released throughout the country by H. J. Heinz Company.

Authors of the book are Dr. H. A. Wooster, Jr., and Dr. F. C. Blanck, of the Heinz Nutritional Research Divi-

(Continued on page 63A)

The new "Maxitron" all-purpose X-ray therapy machine produces the widest range of radiation. General Electric X-Ray Corporation.

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(Continued from page 60A)

sion at Mellon Institute, Pittsburgh. The publication is the successor to the twelfth edition of the company's *Nutritional Charts Book*.

Modernized by the addition of new research findings, *Nutrition Data* includes sections on vitamins, the essential elements, proteins and amino acids, the availability of nutrients, signs and symptoms of malnutrition, the metabolism and action of foods, human nutritive requirements, planning diets for good nutrition and tables of food composition and nutritive values.

The book, due to its technical nature, is available only upon written request by physicians, nutritionists, dietitians, and others qualified by professional duties in the food field.

Send requests to *H. J. Heinz Company, Pittsburgh 30, Pa.*

For brief reference use HP—0206.

New Aerosol Unit

Convenience and economy in the broncho-pulmonary administration of expensive antibiotics are made possible with the new automatic aerosol interrupted demand unit just introduced by the Ohio Chemical & Mfg. Co. The unit, which has been found highly successful in the treatment of acute and chronic infectious sinusitis, broncho-pulmonary diseases and infections, and also for preoperative and post-operative prophylactic medication, features an interrupted demand device which automatically allows the oxygen to nebulize penicillin, streptomycin, and other aerosol antibiotics during the early part of the patient's inhalation only. A special control automatically stops the flow of oxygen and the nebulization of the aerosol during the latter part of the inhalation phase and during the exhalation phase of the breathing cycle. The fully automatic feature of the Ohio aerosol unit makes it equally adaptable for very young, elderly, disorientated, comatose, or critically ill patients. Three interchangeable administration assemblies, a standard size oronasal mask, glass nasal tips, or small size oronasal mask, make it quickly adaptable to the approriate type of patient or treatment.

Automatic Aersal Interrupted Demand Unit for Broncho-Pulmonary Administration of Antibiotics. Ohio Chemical & Mfg. Co., Madison, Wis.

For more information write the *Ohio Chemical & Mfg. Co., Madison, Wis.*

For brief reference use HP—0207.

Jenettes

Bristol Laboratories has announced that Jenettes is the new name for Bristol Penettes, penicillin in a peppermint flavored, all chicle chewing base, like regular chewing gum. Each chewing troche contains 10,000 units of Crystalline Potassium Penicillin G. Jenettes are free from any penicillin taste or odor.

One Jenette slowly chewed will retain a therapeutic concentration of penicillin in the saliva considerably longer than the usual half-hour chewing period.

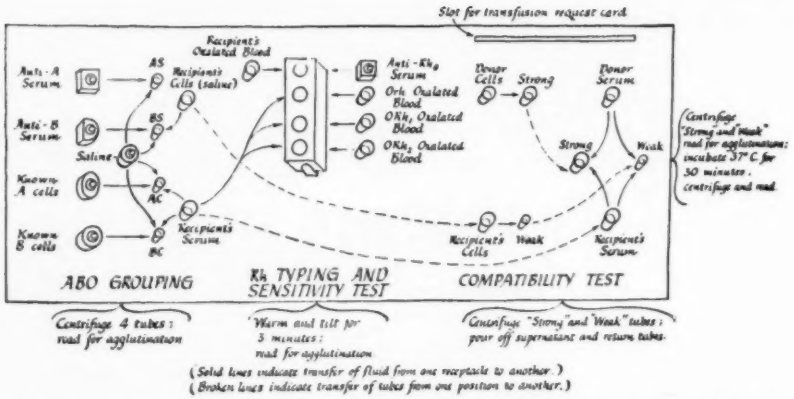
For more information write to *Bristol Laboratories, Inc., Syracuse, N. Y.*

For brief reference use HP—0208.

(Continued on page 64A)

To prevent *dangerous errors* in blood typing

BROWN BLOOD BOARD



Cuts down errors in blood grouping, Rh typing, Rh sensitivity testing and cross matching for transfusion by combining the latest approved technics into a simplified organized procedure. . . . In emergency, permits accurate determinations by doctors and technicians not normally responsible for such testing.

The Brown Blood Board outfit[1] consists of an etched and stamped metal plate on a hardwood base, with an Rh typing box[2], the necessary reagent bottles and test tubes, and anti-serum adapters which will accommodate any commercial anti-serum bottle.

All routine procedures are indicated on the Board by appropriate labelling in different colors, and by flow lines (see cut). The reagent bottles, tubes and adapters are permanently marked in different colors to match the labelling and coloring of their respective positions in the Board; their sizes or shapes also differ, so that they can fit only in their proper positions. A slot in the Board holds the Donor Card and Transfusion Request Form directly in front of the technician while tests are being made.

Brown Blood Board, complete with Rh typing box, anti-serum bottle adapters, and accessories as follows:

A–2800 Includes 3 each labelled, pipette stoppered bottles for Known A, Known B and saline solution; 3 doz. each labelled test tubes for anti-A, anti-B, Known A, Known B, donor cells, recipient cells; 6 doz. unlabelled test tubes; 1 gross dropping pipettes; 1 doz. four-concavity slides.....each $90.00

A–2801 Includes 1 each labelled, pipette stoppered bottles for Known A, Known B and saline solution; and 1 each labelled test tubes for anti-A, anti-B, Known A, Known B, donor cells, recipient cells .....each $56.00

ORDER FROM YOUR SURGICAL SUPPLY DEALER

1. "A Note on Blood Grouping and Cross Matching with Special Reference to a Convenient Grouping Cross Matching Board." I. W. Brown, Jr., M.D. In press.

2. "The Demonstration of Anti-Rh Agglutinins — An Accurate and Rapid Slide Test." L. K. Diamond, M.D., and N. M. Abelson, M.D. J. Lab. & Clin. Med., vol. 30, No. 3, March 1945.

CLAY-ADAMS COMPANY, INC.
141 EAST 25th STREET · NEW YORK 10
Showrooms also at 308 West Washington Street, CHICAGO 6, ILL.

New Supplies

(Continued from page 63A)

Hoffman Tumbler

An automatic unloading tumbler, capable of completely drying 200-pound loads of rough dry work in 15 minutes and of pre-drying the same poundage of flatwork in less than five minutes, has been introduced by the United States Hoffman Machinery Corporation.

With a reversing cylinder 72 inches in diameter, the new tumbler is designed for use in institutional and commercial linen supply laundries requiring large daily production of flatwork. It will make possible single-pass ironing at higher apron speeds in that class of laundries, as well as faster production of fully dried rough work in wiping rag plants.

The new machine, to be called the Hoffman "Grantham" Tumbler, is reported to provide twice the production in less floor space than is required by conventional drying and conditioning tumblers, with an over-all reduction in labor cost. Special design, automatic control, and radiant gas heating are the chief features used to produce these savings.

For information write to the *U. S. Hoffman Machinery Corp., 105 Fourth Ave., New York 3, N. Y.*

For brief reference use HP—0209.

The new Hoffman "Grantham" laundry tumbler unloads 200 lbs. in 30 seconds.

The new Lavoilet is a portable bathroom for bed patients.

Lavoilet

A new era in hospital care is promised by invention of the Lavoilet. The unit is literally a portable and miniature bathroom for bedridden patients.

The flushing Lavoilet will eliminate the nurse's most disagreeable task, rushing and cleaning bedpans. Patients can wash their faces or shave in bed, with hot and cold running water, using the washbasin side of the unit.

The Lavoilet connects with the plumbing system of the hospital through flexible rubber hoses. The portable toilet, which is shallow and rests flat on the bed and flushes at will, eliminates much of the patient's former embarrassment. There can be no overflow following special treatments. The washbasin can also be used as an emesis basin. Out of use, with seat cushions in place, the Lavoilet become an extra chair.

For more information write to the *American Hospital Supply Corp., Evanston, Ill.*

For brief reference use HP—0210.

New Abbott Manager

Norman C. Moore of Portland, Ore., has been appointed manager of a newly created sales district of Abbott Laboratories in the Northwest. Headquarters of the district are in Portland. Previous

(Continued on page 74A)

Fund-Raising Counsel

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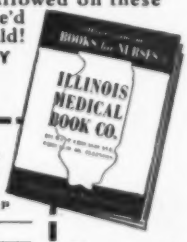

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New Supplies

(Continued from page 64A)

to his appointment as manager, Moore was a special hospital representative for Abbott.

Richard B. Sellars
New president of Ethicon Suture Laboratories, Inc.

New President of Ethicon

Richard B. Sellars has been elected president of Ethicon Suture Laboratories, Inc., New Brunswick, N. J. He will succeed Philip B. Hoffmann who is now chairman of the board. Mr. Sellars was formerly executive vice-president of the concern. He has had broad executive experience in the pharmaceutical field in this country, Canada, England, and Scandinavia.

Neo-Synephrine With Penicillin

A new stable combination package of Neo-Synephrine with Penicillin in "Niphanoid" form is being offered as a prescription specialty by Winthrop-Stearns, Inc.

The package contains one vial of a mixture of 25 mg. *Neo-Synephrine* in "Niphanoid" form and 50,000 units of Crystalline Penicillin G. Sodium. A second vial contains 10 cc. of special buffered isotonic saline solution which is to be used as a diluent. On adding the 10 cc. of diluent to the vial of mixed Neo-Synephrine and Penicillin the resultant solution contains ¼ per cent Neo-Synephrine hydrochloride and 5,000 units of Crystalline Penicillin G. Sodium in each 1 cc. The combination of a decongestant with an antibiotic makes an ideal preparation for the treatment of congestion and infections of the nasal passages. The rapid shrinking action of the Neo-Synephrine gives almost immediate relief and at the same time per-

(Continued on page 76A)

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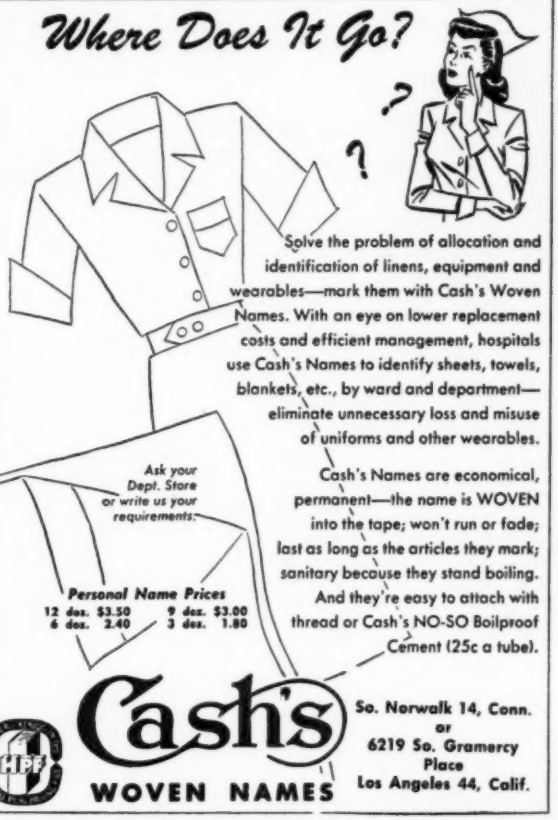

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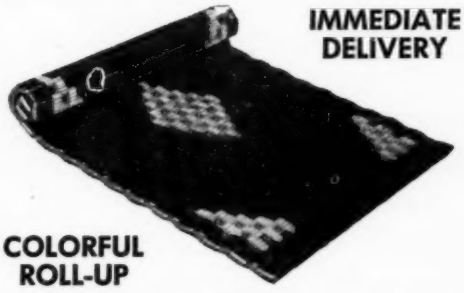

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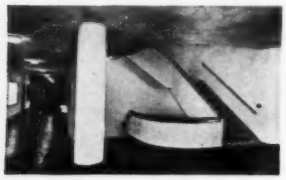

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New Supplies

(Continued from page 74A)

mits much greater diffusion of the penicillin. The potency has been increased as well as the stability. It is pointed out that the combination package will remain stable for one year at room temperature. Refrigeration is not required until the two vials are put in solution.

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For brief reference use HP—0211.

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